



**PROMISING PRACTICES FOR PATIENT-CENTERED
COMMUNICATION WITH VULNERABLE POPULATIONS:
EXAMPLES FROM EIGHT HOSPITALS**

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ABSTRACT: As patient populations become increasingly diverse, health care organizations are looking for innovative ways to communicate effectively across cultures, languages, and health literacy levels. This study identified eight hospitals from across the country that have demonstrated a commitment to providing patient-centered communication with vulnerable patient populations. Through site visits and focus group discussions, the authors draw out “promising practices” from the hospital’s efforts to lower language barriers and ensure safe, clear, and effective health care interactions. The promising practices include: having passionate champions to advocate for communication programs; collecting information on patient needs; engaging communities; developing a diverse and skilled workforce; involving patients; spreading awareness of cultural diversity; providing effective language assistance services; addressing low health literacy; and tracking performance over time. Hospital and health system leaders can use these practices as starting points to encourage patient-centered communication in their own organizations.

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EXECUTIVE SUMMARY

Communication is one of the foundations of health care. Every health care interaction depends on effective communication, from making an appointment and registering for a visit to describing symptoms, discussing risks and benefits of treatments, and understanding care instructions. Good communication is linked to improved patient satisfaction, adherence to medical recommendations, and health outcomes.¹

In the absence of effective communication you have no hope of having a successful outcome.

—Associate Professor of Clinical Medicine,
San Francisco General Hospital

Today, many health care professionals believe that communication is more effective when it is patient-centered, or responsive to a patient's needs, values, and preferences.² While patient-centered communication is often described only in terms of individual clinician-patient interactions, hospitals and health systems can encourage patient-centered communication.³ It is especially important that hospitals and health systems use patient-centered strategies to reach populations that may not receive or understand standard communications. These include patients with limited or no English proficiency, limited health literacy, or cultural backgrounds that are not well understood by hospital or health system staff.⁴

The Ethical Force Program and the Health Research and Educational Trust conducted eight hospital site visits* to learn about patient-centered strategies being used to improve communication with vulnerable patients. Hospitals were selected by a national expert advisory panel based on several criteria, including location, patient diversity, creativity of strategies, and their potential for use at other organizations. Interviews and focus groups with hospital/health system leaders and staff addressed three main topics: 1) organizational factors that led them to develop initiatives to improve patient-centered communication; 2) what they thought every U.S. hospital or health system should be doing to improve patient-centered communication; and 3) lessons learned from their efforts.

Several recurring themes emerged from these discussions, presented in the report as “promising practices.” Hospital and health system leaders can use these practices as starting points to encourage patient-centered communication in their own organizations.

* Caritas Good Samaritan Medical Center, Brockton, Mass.; Harborview Medical Center, Seattle, Wash.; Iowa Health System, Des Moines, Iowa; San Francisco General Hospital, San Francisco, Calif.; Sherman Hospital, Elgin, Ill.; University of Virginia Health System, Charlottesville, Va.; WakeMed Health and Hospitals, Raleigh, N.C.; and Woodhull Medical and Mental Health Center, Brooklyn, N.Y.

PROMISING PRACTICE #1

Encourage Passionate Champions Throughout the Organization

The eight hospitals are committed to communicating effectively with vulnerable populations. This was demonstrated through leaders' support for innovative communication initiatives, and through managers and clinical staff's passion for initiating and sustaining them. In particular, managers and staff were confident that communication initiatives would succeed because their hospitals:

- **Make leadership support visible.** Hospital leaders saw effective, patient-centered communication as a requirement for providing high-quality care and achieving their hospitals' missions.
- **Integrate communication initiatives.** Successful communication initiatives do not stand alone. The initiatives were well integrated into the hospitals' preexisting activities.
- **Start small.** Successful communication initiatives, even large ones, start out small. Once a small program proves that it meets a specific need, it can grow in response to demand.

PROMISING PRACTICE #2

Collect Information to Demonstrate Needs

New communication initiatives are more likely to succeed if the leaders and staff members who implement them can see how they meet specific needs. In some cases patients' communication needs are obvious, in other cases they may be harder to recognize. Hospitals that design and implement communication initiatives are most successful when they:

- **Assess the needs of both patients and staff.** Each of the eight hospitals has methods for assessing the communication needs of individual patients, patient communities, and staff members. These methods complement written surveys.
- **Use data to build support.** Hospital champions build support for new communication initiatives by presenting qualitative and quantitative data on communication needs and hospital performance.
- **Collect information on model programs.** Hospitals rarely develop effective communication initiatives entirely from scratch. Most send representatives to sites that have successful programs in place or consult published guides for instructions.

PROMISING PRACTICE #3

Engage Communities

Each of the eight hospitals has strong ties to its community. These relationships help to keep the hospitals informed of changing patient populations and communication needs. Reliable communication channels also provide opportunities for both sides to share resources and information. Hospitals encourage communities to become engaged when they:

- **Work closely with a community advisory board.** Most hospitals have a community advisory board or another body that includes community members.
- **Collaborate with community organizations.** Community organizations are important partners for health education programs. They can help to raise awareness about local health care services.
- **Partner on specific programs.** Hospitals draw on the experiences and resources in the community by working with them to develop training programs, research projects, and outreach activities.

PROMISING PRACTICE #4

Develop Workforce Diversity and Communication Skills

The eight hospitals believe that health outcomes improve when patients are able to communicate about their health and feel respected by hospital staff. For this reason, each hospital makes it a point to hire staff members who reflect and understand the racial, ethnic, cultural, and other diverse aspects of their patient populations. The hospitals also make communication training accessible and relevant to their staff members. Specifically, the eight hospitals:

- **Recruit and retain diverse staff.** To find qualified candidates who can communicate with diverse populations, hospitals partner with local education institutions and take advantage of community hiring events and resources.
- **Train staff.** Generally, all staff members who interact with patients receive communication training. The training might explore strategies for communicating with respect, working with interpreters, or using the “teach back” method.
- **Watch for communication problems.** Hospital staff help each other to improve their communication strategies and are encouraged to document problems.

PROMISING PRACTICE #5

Involve Patients Every Step of the Way

Every hospital has strategies for involving patients in their own care and using them as resources for improving care. Often, patients offer unique perspectives on the clarity and relevance of hospital documents and communication programs. Hospital staff noted that they get tremendous return on investment when they:

- **Educate patients.** Getting patients involved in their own care means talking to them in ways they can understand and providing information that is relevant to their lifestyles and family situations.
- **Use patients' experiences.** Hospitals can learn from the questions patients ask and the feedback they provide.

PROMISING PRACTICE #6

Be Aware of Cultural Diversity

Most of the eight hospitals serve diverse patient populations. As a result, leaders understand that cultural background can have a strong influence on how patients approach health care and respond to health care information. Cross-cultural communication is most effective when hospitals:

- **Recognize the importance of culture.** Many of the staff members at the eight hospitals believe there is no such thing as cultural “competence.” Instead, they have adopted an attitude of continuous learning.
- **Create a welcoming environment.** Staff note that patients are more willing to communicate if they are comfortable in the hospital.
- **Use interpreters' strengths.** Hospitals often benefit when their interpreters conduct outreach into the community, assist patients with health system navigation, and facilitate discussions across cultures.

PROMISING PRACTICE #7

Provide Effective Language Assistance Services

While interpretation and translation services can be costly, the eight hospitals believe that failing to provide these services can cost even more. For example, the hospitals have found that using qualified interpreters means they provide better-quality care, order fewer unnecessary tests, and quite likely decrease medical errors and the potential for lawsuits. To provide the highest-quality language assistance services, these hospitals:

- **Coordinate interpretation and translation services.** Hospitals that provide language assistance services often have a department to house these services and always have a dedicated staff person to manage them.
- **Assess and train interpreters.** The hospitals that provide professional staff interpreters require that these interpreters undergo training and are regularly assessed on their language and interpretation skills.
- **Assess and train bilingual staff.** Bilingual staff are assessed, and often trained, before they are allowed to provide services in a particular language.

PROMISING PRACTICE #8

Be Aware of Low Health Literacy and Use Clear Language

Limited health literacy skills are more common in some populations than others, but many patients have difficulty understanding complex or unfamiliar health information. This is true among English-speaking and non-English-speaking patients alike. Several hospitals focus specifically on communicating with patients with limited health literacy. Staff members strive to communicate in clear and simple language, avoid jargon, and watch for signs of patient misunderstanding. In particular, these hospitals have learned to:

- **Carefully review documents, educational materials, and signs.** Several of the hospitals are working to make documents, forms, and educational materials clearer.
- **Incorporate “teach back” into processes.** Some hospitals are building the “teach back” method into their processes. In this process, which has been recommended by the National Quality Forum, health providers ask patients to recount information and instructions they have been given.

PROMISING PRACTICE #9

Evaluate Organizational Performance Over Time

All hospitals have budget limitations and have to demonstrate the value of initiatives. To prove that a communication effort has valuable outcomes and deserves ongoing or increased funding, hospitals conduct regular performance assessments. These include staff evaluations, interviews, surveys, grievance reviews, focus groups, and other tools. To track and improve communication performance, the hospitals are working to:

- **Report and track communication problems.** Several hospitals encourage staff members to document communication problems.
- **Link communication performance to outcome indicators.** Most hospitals are developing strategies for tracking the communication performance of staff and interpreters and linking performance to cost savings.

Examples of Ways Sites Demonstrate Promising Practices (part one)

Hospital	#1 Encourage Passionate Champions	#2 Collect Information	#3 Engage Communities	#4 Develop Workforce	#5 Involve Patients
Caritas Good Samaritan Medical Center Brockton, Massachusetts	Interpreters, outreach workers integrated on committees throughout hospital.	Interpreter encounters scheduled and tracked in interpretation department database.	Trained staff interpret at local physician offices. Interpreters trained as insurance counselors.	Communication training linked to quality and safety.	Interpreters visit limited English proficient inpatients twice a day, often with nurse.
Harborview Medical Center Seattle, Washington	Commitment, in mission, to vulnerable populations attracts passionate staff.	Language, race, and ethnicity entered into hospital-wide data system at registration.	“Community House Calls” uses navigator model to link hospital to community.	Incentive pay for language skills. Communication, interpretation competencies.	Respected physicians created legacy of engaging/respecting all patients.
Iowa Health System Des Moines, Iowa	System begins initiatives; senior leaders’ support enables affiliates to adopt them.	Small studies, online community data, and patient stories show needs.	Asks new readers and patients to critique documents, share stories, and advise.	Train with online health literacy module, “Help Your Patients Understand” video.	AskMe3 tool encourages patient questions. Informed consent forms simplified.
San Francisco General Hospital San Francisco, California	Leaders actively support innovation.	Patient language coded at registration. Interpretation dept. tracks encounters.	Immigrant and Refugee Clinic helps community navigate health system.	Incentive pay for language skills. Work-study opportunities for staff members.	Group visits, technology-based interventions help engage individuals.
Sherman Hospital Elgin, Illinois	Committee on limited English proficiency supports communication improvements.	Uses Census data on English proficiency.	Did community needs assessment with local United Way.	Cross-cultural communication staff train at orientations, in-services, meetings.	Staff trained to ask questions in ways that make sense to patients (e.g., weight in lb. or kg.).
University of Virginia Health System Charlottesville, Virginia	Staff members push improved communication at grassroots level.	Collects Census and school district data. Computer registration system tracks communication needs.	Intl. Fam. Med. Clinic, local Intl. Rescue Committee, health dept. link care for immigrants, refugees.	Mandatory, computer-based annual training includes respecting patients and interpretation.	Use of software that “talks” to patients in their language, until interpreters arrive.
WakeMed Health and Hospitals Raleigh, North Carolina	Annual staff evaluations include communication.	Focus groups and “secret shoppers” used to understand patient experiences.	Mentors rural hospitals in region. Works with local groups, community college.	Incentive pay for language skills. Mandatory training on communication.	Began accepting cash payments, hired bilingual financial staff to educate patients.
Woodhull Medical and Mental Health Center Brooklyn, New York	Leaders emphasize strong communication policies.	Grievance data, staff surveys used to identify training needs.	Community board receives updates and provides feedback.	Communication training at orientation; regularly reinforced.	Patient relations visit all inpatients to identify communication needs.

Examples of Ways Sites Demonstrate Promising Practices (part two)

Hospital	#6 Be Aware of Cultural Diversity	#7 Provide Effective Language Assistance	#8 Be Aware of Low Health Literacy	#9 Evaluate Performance
Caritas Good Samaritan Medical Center Brockton, Massachusetts	Outreach and interpretation staff serve as cultural brokers.	Trained, assessed interpreters available 24/7. Office in lobby.	Translated documents tested among patients.	Press Ganey surveys in top languages.
Harborview Medical Center Seattle, Washington	Team up to share cultural experience, meet patient needs. Developed Ethnomed Web site.	If high volume, interpreters should be employees (monitor quality, provide benefits). Some document translation, once English versions are clear and at appropriate reading level.	Information in audio formats.	Survey/interview interpreters to learn about communication gaps.
Iowa Health System Des Moines, Iowa	Increasing focus on cultural awareness, interpretation, translation.	Some document translation, once English versions are clear and at appropriate reading level.	System-wide efforts to introduce “teach back,” simplify forms/documents.	Track Press Ganey patient satisfaction scores. Evaluate use of AskMe3 tool.
San Francisco General Hospital San Francisco, California	Culturally appropriate care focus of Immigrant and Refugee Clinic, care/support groups.	Video Medical Interpretation used to improve access to interpreters on site and across partners.	Automated phone system to help monitor diabetes, Visual Medical Schedules to help patients understand Coumadin use.	All grant-funded projects include assessment on process and outcome measures.
Sherman Hospital Elgin, Illinois	Chaplains advocate respect for diversity, culture, language, spiritual preferences.	Trained, assessed interpreters available 24/7. Community members trained, on-call for rare languages.	National Quality Forum early adopter site for “teach back.”	Cross-cultural communication encounters included in hospital performance reports.
University of Virginia Health System Charlottesville, Virginia	Intl. Fam. Med. Clinic centers care around families. Staff, leadership committees on cultural issues.	Requests for interpreters automatically faxed to coordinator when appointments are made.	Use of “teach back” has reduced surgery delays/cancellations	Track patient follow-up with Intl. Fam. Med. Clinic. Track when interpreters requested, whether they are provided.
WakeMed Health and Hospitals Raleigh, North Carolina	Cultural awareness/sensitivity woven into employee training.	Bilingual staff and interpreters trained, qualify for levels of language skill.	Adjust processes to help patients unfamiliar with accessing health care system (e.g. accepting cash payment for services).	Communication on annual employee evaluation. Track interpreter use, patient/staff survey results, complaints.
Woodhull Medical and Mental Health Center Brooklyn, New York	Art from local artist and flags from patients/staff home countries create welcoming environment.	Trained, assessed interpreters. Trained, assessed bilingual staff language bank.	Training staff to communicate in clear, non-technical language.	Track interpreter use, patient/staff survey results, grievances.

PROMISING PRACTICES FOR PATIENT-CENTERED COMMUNICATION WITH VULNERABLE POPULATIONS: EXAMPLES FROM EIGHT HOSPITALS

INTRODUCTION

High-quality health care depends on good communication.⁵ For example, health outcomes are strongly influenced by how well health care professionals communicate with individual patients and patient communities about disease prevention, symptoms, treatment plans and options, risks and benefits, medication instructions, and other relevant topics. Several national organizations have identified effective health care communication as an essential element of public health and a core component of health care quality:

- Healthy People 2010 included health communication as one of its focus areas and indicated that communication affects each of its 10 leading health indicators;
- the Joint Commission on Accreditation of Health Care Organizations developed standards that require health care organizations to recognize patients' right to and need for effective communication; and
- the National Quality Forum listed effective communication as a way to improve patient safety and a national priority for quality measurement and reporting.⁶

In spite of the widespread recognition that communication is important to health care, patients often feel that health care professionals are not meeting all of their communication needs.⁷ According to the Agency for Healthcare Research and Quality's Healthcare Quality Report, 10.8 percent of adults believe that their health providers sometimes or never listen carefully, explain things clearly, respect what they have to say, or spend enough time with them.⁸ Many patients are intimidated by the prospect of asking questions or expressing concerns during health care interactions.⁹ In particular, patients from racial or ethnic minorities, those with limited English proficiency, or those with less education are likely to have difficulty communicating with their physicians and to rate health care communication poorly.¹⁰

Nearly everyone who works in health care can relate a story about a time when they did not communicate effectively. For example, some of the stories we heard during the site visits include:

- A patient who did not speak English came in to one hospital's emergency department pointing to his ear. The patient was given several expensive tests to

rule out a head injury. It was not until much later that staff members called an interpreter and found out that the patient had recently signed up for health insurance and wanted to get a referral for a long-standing hearing problem.

- In another hospital, a Hispanic quadriplegic patient refused to eat any food brought in by the nursing staff. After several days, a nurse's aide called the interpretation department to help figure out why the patient would not eat. After talking to the patient, the interpreter learned that he was willing to eat, but not the unfamiliar food he was being offered. The hospital's dietitians were able to resolve the problem by providing more culturally appropriate food choices.
- When a young Somali woman died in a hospital, the Somali community converged on the medical examiner's office to retrieve her body for a traditional burial. Standard procedures did not allow for immediate release of the body. To avoid a potential public relations crisis, the hospital's community outreach staff spoke with community leaders and negotiated a solution. A procedure was then put in place to help the hospital, local communities, and the medical examiner resolve similar situations.

Such gaps in communication between health care professionals and patients have been shown to reduce the quality of care, leading to impaired health outcomes and, potentially, health care disparities.¹¹ Thus, one way to improve health outcomes and reduce health disparities is to meet the communication needs of vulnerable patient populations.¹² This report focuses on the communication needs of patients with limited or no English proficiency, limited health literacy, or cultural backgrounds that are not well understood by hospital staff. These vulnerable populations may not understand messages conveyed using standard communication strategies.

Patient-Centered Care and Communication

Health care professionals are increasingly using patient-centered approaches to improve communication with diverse patient populations.¹³ Taking a patient-centered approach means creating health care environments and interactions that focus on what patients need, want, and can relate to based on their particular situations.¹⁴ Broadly, patient-centered health care is defined as “care that is respectful of and responsive to individual patient preferences, needs, and values.”¹⁵

Patient-centered communication is one element of patient-centered care.¹⁶ In this report, patient-centered communication is defined as “communication that is respectful of and responsive to a health care user's needs, beliefs, values, and preferences.”¹⁷ For health care professionals and organizations, this means communicating in ways that draw out

patients' perspective and put them into context, recognize and respect patients' values and beliefs, and encourage patients to take part in their own care and decision-making.¹⁸

Within a hospital or health system, any communication that affects health care users can be patient-centered. This includes communication between physicians and patients, staff members and patients, physicians and staff members about patients, and many other combinations.¹⁹ Verbal, non-verbal, and written communications can all be patient-centered.

Goals of the Study

Most often, patient-centered communication is considered an aspect of encounters between individual clinicians and their patients. While such communication is obviously important, patient care also depends on encounters that occur outside of the examining room. The goal of this report is to identify the role of organizations, specifically hospitals, in supporting and encouraging patient-centered communication.

Many researchers and organizations are trying to figure out the best ways to communicate with patients and patient populations. However, the diversity in patient backgrounds, preferences, beliefs, values, and situations makes it challenging to determine which practices are most effective.

While there may not be “best” practices for improving communication among all patient populations, some practices have shown considerable promise. Based on focus groups and interviews with stakeholders at eight hospitals, this report describes nine promising practices for making communication strategies effective and appropriate. Hospitals, health systems, and other health care organizations can learn from the experiences of the eight hospitals and determine which practices can be adapted to meet their needs and improve communication with their specific patient populations.

PROMISING PRACTICES FOR PATIENT-CENTERED COMMUNICATION IN HOSPITALS

Project and Report Description

In early 2005, the Institute for Ethics at the American Medical Association and the Health Research and Educational Trust solicited nominations of hospitals that had demonstrated a commitment to patient-centered communication with vulnerable populations. In particular, the groups wanted to explore how hospitals were meeting the communication needs of patients with limited or no English proficiency, limited health literacy, or those whose culture was not well understood by staff. Nearly 80 hospitals were nominated and

invited to submit applications for participation in this project. Of the 38 hospitals that submitted complete applications, eight were selected by an expert panel. These were:

- Caritas Good Samaritan Medical Center, Brockton, Mass.
- Harborview Medical Center, Seattle, Wash.
- Iowa Health System, Des Moines, Iowa
- San Francisco General Hospital, San Francisco, Calif.
- Sherman Hospital, Elgin, Ill.
- University of Virginia Health System, Charlottesville, Va.
- WakeMed Health and Hospitals, Raleigh, N.C.
- Woodhull Medical and Mental Health Center, Brooklyn, N.Y.

Site selection balanced the need to choose a range of hospital sizes and types, geographic regions, populations served, and focus areas. The expert panel also selected hospitals that had programs at various stages of development. For a detailed description of the selection and study methods, see [Appendix B: Project Methodology](#).

Staff members from the American Medical Association and the Health Research and Educational Trust conducted two-day site visits at each of the eight selected sites. Interviews and focus groups with hospital leaders and staff addressed three main topics: 1) organizational factors that led them to develop initiatives to improve patient-centered communication; 2) what they thought every U.S. hospital or health system should be doing to improve patient-centered communication; and 3) lessons learned from their efforts.

In some cases, patient-centered communication initiatives began because of a change in leadership or a top-down decision. In others, the initiatives originated with clinical staff or mid-level managers. In both cases, participants recognized that initiatives succeeded because of organization-wide commitment to providing effective communication and the highest-quality care to all patients. While the eight hospitals followed various strategies, certain common lessons emerged from their work. These are described in this report as promising practices.

Many hospitals may already follow some of these promising practices, although they may not use them specifically to improve communication. By applying these

practices to communication issues, hospitals and health systems can strengthen the process of informed consent, ensure safety, raise the quality of care, and make other improvements to patient care.

PROMISING PRACTICE #1

Encourage Passionate Champions Throughout the Organization

Hospital leaders make frequent decisions about which initiatives to fund, what topics to include in workforce training, and where to focus quality improvement efforts. In most cases, the issues that stay near the top of the priority list have hospital-wide commitment. Building commitment for an initiative is a process. It requires someone to have an idea, build a case and generate support for it, and advocate for funding, staff time, and other resources. Without a champion or champions consistently advocating for an initiative, even one started by a senior leader will not last over time.

Within the eight hospitals, the initiatives that take a patient-centered approach to communication have a passionate champion. In many cases the champion is a mid-level manager who recognizes a need, holds enough power to encourage change, and is capable of building support. These champions have the confidence to advocate for communication initiatives because:

- hospital leaders encourage individuals to come up with new ideas, especially if they benefit vulnerable patient populations;
- initiatives to improve communication are integrated into other activities; and
- new initiatives start small so that their value can be tested.

Make leadership support visible. Leaders at the eight hospitals see effective, patient-centered communication as a requirement for providing high-quality care and achieving their hospitals' missions. This message is spread through the hospitals in several ways. The importance of good communication is written into policies and included in talks and presentations given by senior leaders. In addition, small-scale funding is available to test new initiatives for improving communication.

The eight hospitals have missions that emphasize the importance of providing high-quality care to diverse populations. Most are considered the local safety-net facility, and cannot or do not refer vulnerable populations elsewhere. Staff members feel that everyone working in the organization has a common understanding of the hospital mission and how good communication contributes to it. Communication that is respectful, clear, and considerate of patients' needs is seen as a requirement for providing

the right care to patients who come from diverse cultural backgrounds, have limited English proficiency, or limited health literacy skills.

At the eight hospitals, staff members say they are comfortable calling interpreters or taking extra time to explain information to patients because written policies encourage these behaviors. Policies that outline goals and requirements for communication also give staff members confidence that the administration will support innovative efforts to improve care for vulnerable populations. Examples of policies that support patient-centered communication include:

- At WakeMed Health and Hospitals, annual employee evaluations are 70 percent demonstrating technical skills and 30 percent meeting organizational standards, including commitment to understanding patients’ cultures and improving communication skills.
- Several hospitals have written policies that strongly discourage or prohibit a patient’s family members or friends from being used as medical interpreters (Harborview Medical Center, Sherman Hospital, Woodhull Medical and Mental Health Center, and WakeMed Health and Hospitals).
- Three Iowa Health System sites have policies mandating that new patient education materials must be approved by patient education committees (the Finley Hospital, Iowa Home Health Care, and Trinity Regional Medical Center Fort Dodge).
- University of Virginia Health System has a “policy on policies” that provides guidance for clearly writing, classifying, and disseminating new policies.

In other hospitals where I’ve worked, we felt like paging an interpreter was an expensive commodity. Here it is okay to page an interpreter to help you make rounds. This is an expectation and not a luxury.

—Clinical Coordinator,
Labor and Delivery, Sherman Hospital

If you have the energy and time commitment to do something, people will allow you to do it.

—Executive Administrator,
San Francisco General Hospital

Managers adhere to these policies and demonstrate effective, patient-centered communication, further encouraging staff to follow their lead. Hospital mission statements and related policies are typically introduced by a senior executive during new employee orientations. Policies are further reinforced during management and department

meetings, grand rounds, and in-services as well as in hospital newsletters.

Finally, hospital leaders encourage staff to come up with innovative ideas for improving communication. Leaders listen to new ideas, discuss ways they can be implemented, and either provide resources to test them or support staff members in applying for funding.

Integrate communication initiatives. Successful communication initiatives rarely stand alone. Instead, they are well integrated into the hospitals' preexisting activities, such as budgeting schedules, management structures, quality improvement efforts, and education and training programs.

Instead of introducing communication improvements as something entirely new, the eight hospitals integrate communication initiatives into ongoing programs in areas such as quality improvement, patient safety, risk management, informed consent, or diabetes or prenatal education.

- Woodhull Medical and Mental Health Center embedded new communication initiatives, including language assistance, a customer service program, and workforce training, into existing departments and initiatives. This facilitated their introduction and ensured the efforts would be spread throughout the organization. However, it also made it difficult to determine the impact of the new initiatives.
- The Iowa Health System has used the Institute for Healthcare Improvement (IHI) rapid-cycle model for quality improvement. Staff members adapted the model of teams, collaborative learning, and small tests of change to address health literacy.

It is important to consider where departments such as interpreter services and cross-cultural communication are located in the hospital hierarchy. In the eight hospitals, the managers of these departments may report to a senior leader of nursing or patient services. The hospitals believe that reporting to high-level executives, particularly clinical executives, enables communication staff to participate in leadership meetings and makes the departments visible and respected in clinical service areas. Other ways to make communication programs visible are to include representatives from every department in planning them and allow advocates to participate on hospital committees such as ethics, patient education, patient tracer, and community benefits.

If you don't recognize a program as a formal service of the hospital, it's not going to work that well.

—Chief Operating Officer,
Sherman Hospital

*Interpreter services aren't ancillary—
they're really a part of our day-to-
day patient care.*

—Social Worker, Caritas Good
Samaritan Medical Center

Start small. Successful communication initiatives, even large ones, start small. Once a small program proves that it meets a specific need, it can grow in response to demand. Communication initiatives for vulnerable populations often require changes to organizational culture, even in the most committed organizations. It is important to recognize that culture change takes place gradually, not overnight.

Some hospitals use their experience with the IHI rapid-cycle model for quality improvement (Woodhull Medical and Mental Health Center and Iowa Health System).

- The hospitals ask staff members to make small changes over a short period of time with a few patients. This tests the effectiveness of new methods and helps staff members experience their value.
- New methods or strategies that are shown to be effective are disseminated through the hospitals.

PROMISING PRACTICE #2

Collect Information to Demonstrate Needs

Hospitals collect information about the communication needs of their patient populations for many reasons. Such information helps them to develop programs that are seen as relevant and valuable by leaders, staff members, patients, and communities. Patient-centered communication initiatives are more likely to succeed if leaders and staff members can track their effects on communication and quality of care.

When planning ways to improve patient-centered communication, the eight hospitals:

- ask patients and staff members about their communication needs and strategies that might meet those needs;
- draw on real-time data from patient populations to demonstrate why certain strategies are needed; and
- use examples and models from other organizations to identify effective strategies for meeting communication needs.

Assess the needs of patients and staff. Each of the eight hospitals has methods for assessing the communication needs of individual patients, patient communities, and staff members. These methods complement written surveys. In such assessments, it is especially important to consider the needs of staff members whose work patterns may be disrupted by new communication initiatives. Staff who are not convinced that an initiative will help can become a significant, sometimes insurmountable, barrier. But if these same staff members are convinced of the benefits, they often become powerful advocates for communication initiatives.

If we're here to serve, we have to know whom we are serving.

—President, Caritas Good Samaritan Medical Center

Community needs. All eight hospitals gather information on the communication needs of their communities, including education levels, languages, cultures, and ways in which patients access care and relate to health care professionals. Common sources of information include the U.S. Census, local school districts, post offices, police stations, the hospital emergency department, focus groups, and small-scale studies.

- After looking at emergency department admissions data, Woodhull Medical and Mental Health Center identified a Hasidic Jewish population and populations of day laborers from several African countries as groups who lived near the hospital but rarely used its non-emergency services. In response, Woodhull leaders began conducting outreach into these communities to learn what they understood about the health care system and what services they most needed. For instance, the Hasidic community was concerned about several young men who had died of heart attacks, so the hospital began doing presentations and education on risks factors for heart disease. For local day laborers, the hospital incorporated additional evening hours into the clinics and brought screening events to accessible community locations.
- Sherman Hospital uses Census data to find out what percentage of patients in the immediate zip code report that they speak English “not at all” (and thus definitely need an interpreter) or “less than very well” (and thus may need an interpreter).
- Hospitals in the Iowa Health System have used medication reconciliation studies, online adult literacy estimates, and patient interviews to learn about the prevalence and impact of limited literacy and health literacy skills.²⁰

Staff needs. Several hospitals noted that communication training and interventions are more successful when they address problems identified by staff.

- Woodhull Medical and Mental Health Center surveys staff members to find out what resources they have and what they need. Recent examples of identified needs include forms in Polish, in addition to English and Spanish, multilingual signs, and additional languages for the Patient Bill of Rights.
- The manager of interpretation services at WakeMed Health and Hospitals meets with the managers of all clinical areas and reviews admissions data to see what areas of the hospital have the highest volume of Spanish-speaking patients and the greatest need for interpreters and bilingual staff.

Individual needs. The hospitals that are most satisfied with their ability to collect communication information have the ability to enter this information in a computer system when patients are registered. Appropriate staff can see and update this information as patients move through the hospital.

- The computerized registration system (A2K3) at University of Virginia Health Systems has a field for special needs in which workforce members can indicate if a patient has communication needs. Once this field is checked, users are prompted to specify need for a particular language, choose a language, or specify “other.” Users can then enter additional languages, health literacy needs, or other communication needs into the database.
- In addition to including information on communication needs in computer systems, some hospitals include this information on patient charts. Interpreters at Caritas Good Samaritan Medical Center include a red form in the record of every patient who requires an interpreter. The form identifies the language needed, notes if the patient speaks any English or can read in his or her own language, and briefly outlines instructions for contacting and using interpreters.

Most of the hospitals note that tracking patient communication needs is a challenge. In many cases, hospital registration software does not contain the data fields needed to collect detailed communication information. In other cases, information collected by the system is not easily accessible across the hospital.

Use data to build support. Hospital champions often build support for new communication initiatives by presenting qualitative and quantitative data on common communication needs and hospital performance. This includes data on the cultural backgrounds, languages, and literacy levels of the hospitals’ patient populations.

Several hospitals note that personal stories and hospital-specific data are powerful tools for building support for communication initiatives.

- Staff within Iowa Health System found that clinicians often did not realize the impact of limited health literacy until they saw data from their own hospital and heard from patients in their own community who struggled with literacy and health literacy.²¹
- Staff at University of Virginia Health Systems’ general medicine clinic conducted several studies to document the level of health literacy among patients and to determine resident perceptions of who is health literate. The study found that resident perceptions were often wrong, both overestimating and underestimating patients’ health literacy levels.
- As part of a planning grant, WakeMed Health and Hospitals conducted a series of “secret shopper” visits to determine patient experiences with different areas of the hospital. The hospital found that, in many cases, staff members were not able to communicate with patients who did not speak English.

Know the different languages spoken and the educational levels of the patients in your community. I think that’s fundamental.

—Medical Staff Interpreter, Woodhull Medical and Mental Health Center

None of the eight hospitals put communication initiatives in place in response to national standards or regulations, such as the Office of Minority Health’s Culturally and Linguistically Appropriate Standards (CLAS), Title VI of the Civil Rights Act, or Joint Commission on Accreditation of Healthcare Organizations standards. However, leaders often reported that standards, laws, and other requirements are important to justifying program growth and defending their programs against budget cuts.

Collect information on model programs. Hospitals rarely develop effective communication initiatives entirely from scratch. Most send representatives to visit sites that have successful programs in place or consult published guides for instructions. After seeing what works in similar settings, hospitals adapt relevant strategies to meet the needs of their patient populations.

- In February 2001, Woodhull Medical and Mental Health Center sent a team to visit the Cambridge Alliance to observe and learn from its cultural diversity and language programs.
- WakeMed Health and Hospitals visited other North Carolina institutions, including a regional health department, to see how sites serving similar populations offered language assistance services.

PROMISING PRACTICE #3

Engage Communities

The leaders and staff members at each of the eight hospitals recognize the importance of being a part of their patients' communities. They feel that understanding their patients' demographics, education levels, languages, and cultures is essential for hospital planning. Engaged community members and groups provide hospitals with feedback on local needs and resources, and hospitals, in turn, provide communities with information on health and health care. Patients only spend a short amount of time with their physicians or in hospitals. The rest of the time they spend caring for themselves and their families in their communities.

Individuals and community groups are excellent sources of information on how patient populations access health care and relate to the health care system. They are also good resources for spreading information about hospital services and programs. When hospitals engage with their communities, the communities benefit by having reliable sources for health care information, audiences for their concerns about local health care services, and partners for programs to improve health care.

Hospitals encourage community members and groups to become engaged in hospital initiatives when they:

- invite or appoint community members to serve on boards and committees that regularly interact with hospital staff to provide advice and feedback;
- collaborate with community organizations to share resources and information about health care and local health care services; and
- partner with community organizations on specific programs to improve health care communication throughout the community.

*What we've been able to do here—
not only with our interpreter services
but across the board—is to recognize
the community that we live and
work in and that we serve.*

—President, Caritas Good Samaritan
Medical Center

Work closely with a community advisory board.

Most hospitals have a community advisory board or another body that includes community members. Hospitals often use meetings of these boards to present information on new hospital programs, solicit feedback about ongoing programs, and discuss ways to communicate information about health and health care to community members.

Hospitals use these boards to build relationships within the community. The community members are often invited or appointed by a hospital leader, local politician, or community group.

- The chief executive officer (CEO) at Sherman Hospital appoints community members to serve on the hospital's governing board. As members retire from the board, the CEO strives to find new members who represent the community's demographic profile.
- As part of the New York public hospital system, Woodhull Medical and Mental Health Center is required to have a community advisory board. The board meets monthly and serves as an advocate for the community.
- Harborview Medical Center has a community advisory board specifically for its Community House Calls program. The hospital uses this board to establish relationships with local community groups, learn from community members, understand community-specific issues, and provide a forum in which the hospital can receive feedback from its communities.

Collaborate with community organizations. Community organizations are important partners for health education efforts and for raising awareness about local health care services. Hospital staff contribute to such partnerships when they volunteer on boards, participate in local events, make presentations to local groups, and use community feedback to improve services.

Several hospitals are working to improve health care communication outside their own walls by helping physicians in the community or smaller hospitals in their regions.

- Caritas Good Samaritan Medical Center's patients can request that one of the hospital's interpreters accompany them to appointments at a local clinic or physician office. There is no charge for this service, even if the clinics or physicians are not affiliated with the hospital. Other local health care providers, such as hospices and nursing homes, can use the hospital's interpreters for a fee.
- WakeMed Health and Hospitals mentors rural hospitals in its region on how to provide language assistance services. For example, hospital staff help to assess bilingual staff and review translated documents.
- Woodhull Medical and Mental Health Center creates relationships with non-affiliated community physicians by allowing them to refer patients to hospital specialists and giving them copies of patient test results.

To build relationships within the community, hospital staff often serve on the boards of local organizations.

- While developing cross-cultural communication programs, senior executives from WakeMed Health and Hospitals regularly met with community leaders and attended meetings on how to address the needs of the area’s growing Hispanic population.
- The manager of Caritas Good Samaritan’s community outreach and interpreter services department sits on the board of the local Rotary Club, community college, and hospice.
- University of Virginia Health Systems works closely with the local International Rescue Committee (IRC) and health department to coordinate the health care of refugees in Charlottesville. Without the IRC as a partner, the hospital would have to expend greater resources in caring for diverse refugee populations, including social workers, case managers, and interpreters for rare languages.

Partner on specific programs. Hospitals draw on the experience and resources of community members, leaders, and organizations by working with them to develop training programs, research projects, and general outreach activities.

If we want to compete in our local area, we need to be able provide [interpreters and community outreach] to the populations.

—Director of Patient Access,
Caritas Good Samaritan Medical Center

- The Iowa Health System encourages its hospitals to ask patients to review hospital documents for clarity. Hospitals often use their own volunteers as patient reviewers or contact adult learning centers associated with local community colleges or high schools.
- To increase the pool of individuals qualified to serve as medical interpreters, WakeMed Health and Hospitals is working with the Wake Technical Community College to develop an associate degree program. Courses will be offered online and at various campuses and the clinical rotation component will take place at the hospital’s main campus.

PROMISING PRACTICE #4

Develop Workforce Diversity and Communication Skills

Leaders at the eight hospitals believe that patients feel more comfortable in the hospitals and are more open to communicating if they can interact with staff members who share

their languages and cultural backgrounds. For these reasons, the hospitals work with their communities to recruit staff members from the community. The hospitals also focus attention on communication training. Staff members need to develop and practice their skills in communicating respectfully and understandably across languages, cultures, and educational backgrounds. Finally, the hospitals emphasize the importance of good communication. When staff members recognize communication problems, they are encouraged to document and discuss them.

- The hospitals work with their communities to recruit and retain staff members by creating training opportunities, advertising available positions, creating appropriate incentives, and making the hospital a place people want to work.
- The hospitals train staff members on communication skills and how to access the resources, such as telephonic interpretation services, on-site interpreters, and visual aids.
- When communication problems arise, the hospitals have strategies for helping staff members identify and solve them.

Recruit and retain diverse staff. To find candidates who can communicate with diverse populations and are qualified to work in health care, hospitals partner with local education institutions and take advantage of community hiring events and resources. Hospitals sometimes make positions more attractive to bilingual applicants by offering a pay incentive for language skills or by making language skills a job requirement.

To build a qualified applicant pool, hospitals are working with community colleges to develop training programs for interpreters and other specialties. In some cases, current staff members are given time and funding to get additional training and build skills for job advancement.

- WakeMed Health and Hospitals is working with the Wake Technical Community College to develop an associate degree program for medical interpreters.
- Caritas Good Samaritan Medical Center has scholarship and work release programs to help existing staff build skills, including licensed practical nurse and certified nursing assistant training.
- San Francisco General helps employees pursue educational opportunities by paying them for 40 hours of work if they work for 20 hours and go to school for 20 hours.

Several hospitals are developing employment opportunities for interested community members.

- The manager of Interpretation and Translation Services at WakeMed Health and Hospitals works with a community group, ProFamilia, that helps new immigrants learn English and find jobs.
- WakeMed Health and Hospitals has also received a Community Health Improvement grant to train Spanish speaking individuals to work as patient account representatives. These individuals learn English in addition to the registration, insurance, and billing processes.
- At Caritas Good Samaritan Medical Center, interpreters often attend orientation sessions to welcome new staff members who are not proficient in English and help them fill out paperwork.

While most of the hospitals include a language preference in job descriptions, three make language skills a qualification for certain registration and first contact positions (Woodhull Medical and Mental Health Center, WakeMed Health and Hospitals, and San Francisco General Hospital). To attract bilingual staff, some hospitals offer pay incentives for using language skills (WakeMed Health and Hospitals, San Francisco General Hospital, and Harborview Medical Center).

Training has to be ongoing, and the message needs to be in your system, your policies, in how you are providing care to your patients.

—Human Resources, Woodhull Medical and Mental Health Center

Train staff. In the eight hospitals, staff who interact with patients receive communication training on such issues as communicating with respect, accessing and using interpreters, speaking clearly, and employing the “teach back” method (in which health providers ask patients to recount information and instructions they have been given). Training is most effective when it is introduced gradually, offered in

flexible formats, and frequently reinforced.

Training on new communication initiatives is typically introduced gradually to build momentum and give program staff time to meet increasing demand for services.

- Woodhull Medical and Mental Health Center began training for its language assistance programs with new employees during corporate orientation. Training on how to access and use interpreters was then offered to current staff as optional

seminars and added as a topic to town hall meetings, grand rounds, and other events. Eventually, training was made mandatory.

- Iowa Health System hospitals started “teach back” training gradually, asking only a couple of physicians to use the method with the last patient before lunch or the last patient of the day. Many Iowa Health System affiliates introduce health literacy during all employee orientations.

Hospitals find that training is most effective when it is flexible and offered at multiple times and in multiple formats.

- Woodhull Medical and Mental Health Center schedules half-hour to one-hour training sessions in the morning, with repeat sessions in the afternoon. Some of these sessions are mandatory, some are optional, and some require managers to attend and bring information back to their staff members. The sessions are often videotaped for later use.

It is important to reinforce staff member’s communication training by incorporating messages and lessons into routine events.

- Several hospitals offer grand rounds, noon-time forums (with lunch), and speakers that address the topics of cross-cultural communication and language assistance (Woodhull Medical and Mental Health Center and Caritas Good Samaritan Medical Center). In addition, interpreters at most of the hospitals begin every encounter by introducing themselves to the patient and the clinician and briefly explaining how the conversation will proceed and how to best communicate using an interpreter (for example, reminding the clinician to speak directly to the patient rather than to the interpreter, and reminding the patient that the interpreter is a professional who will repeat exactly what is said and that the entire encounter is confidential).
- WakeMed Health and Hospitals incorporates cross-cultural communication messages into manager training as well as its mandatory online training program.
- At Caritas Good Samaritan Medical Center, the manager of interpretation and community outreach conducts continuing medical education (CME) events that link interpretation services to topics such as patient safety.
- Some hospitals include accessing and working with interpreters as nursing competencies (Sherman Hospital and Harborview Medical Center).

Finally, the hospitals suggest that communication training should be linked to issues such as patient safety and health care disparities and centered on clinical topics that are relevant to the hospital's patient populations.

Watch for communication problems. Hospital staff help each other improve their communication skills and are encouraged to document problems. For recurring problems, hospitals have processes to identify the causes and address them.

Communication is the underlying basis for every complaint.

—Patient Relations Staff Member, Woodhull Medical and Mental Health Center

To help each other communicate better, staff members often work together.

- At WakeMed Health and Hospitals, clinicians appreciate the ability of interpreters to serve as cultural brokers. The interpreters help the clinicians understand what may offend patients, how to ask questions, and how to communicate when patients do not understand something.
- In some cases, hospital staff ask interpreters to perform duties that are beyond the scope of their responsibility as interpreters. Interpreters, or their managers, then have to remind staff members of the appropriate roles of interpreters.
- Finally, staff members at several of the hospitals note that they listen to how their co-workers communicate with patients. If they notice a problem, they work together to figure out how to ask a question or explain a piece of information better. For example, Sherman Hospital's interpreters helped the birth registrar modify some of the questions she asks in order to solicit more accurate responses.

When communication problems come up, it is important to have a system in place to report, document, and address the problems.

- For example, Woodhull Medical and Mental Health Center addresses grievances through its Patient Relations Department. When this department receives a grievance, it contacts the patient to better understand the problem and attempts to resolve it. If staff cannot do so, they ask the patient to put the complaint in writing. Patient Relations then contacts the department head and talks to the staff member who is the subject of the complaint. Patient Relations staff then notify patients of the outcome or the expected time by which an outcome will be reached. All grievances are entered into a database, which is used to identify training needs and generate monthly reports for department heads and the quality council.

PROMISING PRACTICE #5

Involve Patients Every Step of the Way

Each of the eight hospitals has strategies for involving patients in their own care and using patients as resources for improving care throughout the hospital. One strategy is to educate patients about their health and health care. The eight hospitals make it a point to match education strategies to their patient populations, talking to patients about their communication needs and developing innovative ways to address them.

Hospitals also use the knowledge and experience of their patients. Patients are the best source of information on how well the hospital is communicating and how it can do better. They often provide a unique perspective on the clarity and relevance of hospital documents and communication programs.

Overall, hospital staff note that they get tremendous return on investment when:

- they educate patients about health and health care in ways patients can understand and use; and
- they find out how well staff members communicate by asking their patients.

Educate patients. Getting patients involved in their own care means talking to them in ways they can understand and providing educational information in formats that are relevant to their lifestyles and family situations. Hospitals prepare patients to participate in their own care when staff members provide education about what patients need to do and what resources are available to them.

- Interpreters at Caritas Good Samaritan Medical Center are specifically trained to educate patients about available health insurance options, including the fact that applying for programs will not affect immigration status.
- WakeMed Health and Hospitals learned that some patients were not paying their medical bills because they did not know how to do it with cash. The hospital first developed a way to take cash payments and then hired bilingual financial representatives to educate patients.

It starts when patients are admitted. A patient representative comes down and finds out what their needs are. That communicates straightaway that we are taking them seriously and care about them being able to express themselves and being able to hear us.

—Mental Health Provider, Woodhull Medical and Mental Health Center

- San Francisco General Hospital has developed several programs that use group settings to educate patients and engage them in their own care. Projects such as Cancer Awareness Resources and Education (CARE), Centering Pregnancy, and the IDEALL Project (Improving Diabetes Efforts Across Language and Literacy) bring patients together to explore their health and health care. In addition to providing social support and education, the programs give patients more time with health care professionals than they would get during one-on-one visits.

Talk to patients. To create a welcoming environment for patients, it is important that staff members talk to them—even if they do not speak the same language.

- In one instance, a WakeMed Health and Hospitals patient said he wanted to leave the hospital before a scheduled surgery because he thought the staff hated him. None of his nurses had spoken to him because he did not speak English. After the nurses found out about this, they made a point to smile and speak to him in English, even if he didn't understand. He appreciated their efforts and felt welcomed and comfortable.
- At Woodhull Medical and Mental Health Center, representatives from the patient relations department visit every hospital inpatient to discuss their rights and determine any communication or language needs.
- At Caritas Good Samaritan Medical Center, interpreters visit every inpatient with limited English proficiency twice a day. The hospital has, on average, 10 to 12 such patients at a time. When possible, nurses participate in these visits, giving them at least one opportunity per shift to communicate with their patients.

Use technology. All of the hospitals use some form of technology to improve how they communicate with patients. Nearly all have access to telephone-based interpretation services. Several also use video-based interpreter services.

- When interpreters are on site, staff members can often arrange for a three-way call, between patients, interpreters, and health care providers, to take place immediately.
- For languages that are not available on site, hospitals typically have a contract with an off-site professional medical interpretation service, such as Cyracom, Language

Explain to patients what 'informed consent' is and why hospitals need it. Many patients from outside the U.S. don't have a concept of liability.

—Director, WakeMed Faculty Physicians Obstetrics/Gynecology, WakeMed Health and Hospitals

Line, or Pacific Interpreters. Such services provide professional interpretation for languages that hospital staff rarely encounter or cannot identify.

- San Francisco General Hospital is beginning to use video medical interpretation. With use of a flat-screen monitor with an attached video camera, interpreters who are in the hospital or at another location provide interpretation. This method is similar to the DeafTalk video system used by Caritas Good Samaritan Medical Center and Sherman Hospital for sign language interpretation.

Other uses of technology include:

- MultiTerm: Sherman Hospital purchased terminology management software, designed for translators, to develop a common repository for translated words, phrases, and ideas. This ensures that in-house translations are consistent and helps interpreters document and share what they learn in their encounters.
- MedBridge Software: University of Virginia Health Systems recently introduced a computer program that allows staff members to communicate, on a temporary or emergency basis, with patients who do not speak English. Patients can read the questions they are being asked on a computer screen in their primary language as well as English. Staff members' questions are also read out loud by the computer in the patients' language.
- Visual Medical Schedules: San Francisco General Hospital's anti-coagulation clinic uses a computer program to create a visual image of a patient's weekly medication schedule.²² The schedule helps physicians and pharmacists communicate with patients about medication schedules by showing a picture of how much of each medication patients need to take each day.
- Automated Phone System for Diabetes Management: San Francisco General has developed an automated phone system to do diabetes education and surveillance with a sample of patients. Patients select their preferred language and receive weekly automated phone calls that provide basic educational messages and ask questions that require touch-tone responses.

Use patients' experiences. Hospitals can get a lot of information from the questions patients ask and the feedback they provide. The only way to find out how well some communication programs are working is to ask patients. Patients can also be good resources for educating one another about hospital health care services.

- The Iowa Health System encourages its hospitals to ask patients to review hospital documents for clarity. Hospitals often use their own volunteers as patient reviewers or contact adult learning centers associated with local community colleges or high schools.
- As part of its Cancer Awareness Resources and Education (CARE) program, San Francisco General Hospital is planning to start a volunteer brigade. Graduates of the hospital's CARE program will volunteer to help other cancer patients learn about and live with their illness.

PROMISING PRACTICE #6

Be Aware of Cultural Diversity

Patients' cultural backgrounds can influence their interactions with the health care system and communications with hospital staff. The eight hospitals recognize that their patient populations come from diverse backgrounds. Many staff members at the hospitals view this diversity as an asset and try to find ways they can learn from the patients they serve.

In most cases, hospital leaders encourage a team-based approach to cross-cultural communication. With experience, staff members learn to recognize when a communication problem may have a cultural component. Staff members then call on their colleagues—including interpreter staff—from different disciplines, specialties, and cultural backgrounds to work together to find a solution.

When communicating with patients across cultures, hospital staff find that it is important to:

- recognize and understand the important influence of culture on health care interactions;
- create an environment that is respectful of and welcoming to patients, regardless of their cultural background; and
- use the experiences and strengths of staff members throughout the hospital, especially the interpreters.

Recognize the importance of culture. In many cases, staff members at these eight hospitals believe there is no such thing as cultural “competence.” Instead, they have adopted an attitude of continuous learning that focuses on cultural awareness. They are aware of their own cultural values and beliefs and seek to understand how patients' cultural values and beliefs affect health care.

- Some staff members at Harborview Medical Center advocate for use of the term cultural “humility” instead of cultural “competence.”²³ This shift emphasizes that to effectively serve patients from diverse, and often changing, cultural backgrounds, the best strategy is maintain humility about how much you know and be open to learning how to serve your patients from the patients

I don't presume to be culturally competent. I presume to be humble and open to what I can learn about patients' cultures and what they mean in their health care interactions.

—Certified Nurse Midwife, Centering Pregnancy, San Francisco General Hospital

- themselves. The staff members also recommend against assuming that everyone has the same beliefs and level of knowledge about health care.
- WakeMed Health and Hospitals requires staff members to attend mandatory training sessions on cultural awareness and respect for diversity.
- The manager of interpretation at Sherman Hospital encourages cultural awareness training sessions to help people explore their own cultural influences and contexts. She discourages the belief that someone can become “culturally competent” simply by using a list of characteristics as a guide for interactions with a certain group of patients. Cultural awareness training should encourage staff members to communicate with patients about what patients want and need, instead of making assumptions.
- Staff members at Sherman Hospital also have changed how they give advice and ask questions. For example, during diabetes education, staff switched from telling patients what they should eat to asking what they typically eat. This enables educators to discuss foods with which patients are familiar.
- Harborview Medical Center created a Web site (<http://www.ethnomed.org>) to document staff members' experiences caring for patients from diverse cultural backgrounds, including many refugees from war-torn nations. The site describes patients' cultural beliefs, medical issues, and other pertinent information. It serves as a reference for health care practitioners at Harborview and is also publicly available. The site is often included in presentations on Harborview's cultural initiatives and it is widely referenced in the Internet resource guides of libraries, hospitals, public health systems, and other organizations such as the Institute for Healthcare Improvement and the Joint Commission on Accreditation of Healthcare Organizations.

Create a welcoming environment. Staff at the eight hospitals note that patients are more willing to communicate when they feel comfortable in the hospital environment.

Hospitals can create welcoming environments by displaying art from local artists, providing culturally appropriate food choices, and making culturally specific clinics available.

- Woodhull Medical and Mental Health Center displays artwork commissioned from a local artist. In addition, it displays flags from patient and staff members' countries of origin as a visual reminder that everyone is welcome in the hospital. On "culture-sharing days," staff members bring in food or wear clothing representative of their cultural backgrounds.
- WakeMed Health and Hospitals provides closed-circuit television programs in Spanish.

Three of the hospitals have international clinics that focus specifically on meeting the needs of immigrant and refugee families.

- University of Virginia Health Systems' International Family Medicine Clinic coordinates care for immigrant and refugee families in the Charlottesville area. Patients are seen by clinic physicians who are familiar with their health history, who also treat and know the health history of their family members, and who are able to refer patients throughout the hospital as needed. The clinic works closely with local representatives from the International Rescue Committee and public health department.
- Harborview Medical Center's International Medicine Clinic provides health care services to refugee and immigrant patients, including on-site interpretation, assistance with health system navigation, and facilitation of conversations and medical decision making across cultures. The clinic offers a range of services, including internal medicine, mental health, pharmacy, travel medicine, nutrition, and social work.
- San Francisco General Hospital's Immigrant and Refugee Clinic manages the care of recent immigrants and refugees. Staff are hired for the clinic based on the most common languages and cultural needs; as needs change, new staff are hired. This clinic also houses the Newcomers Health Program, a state-sponsored program that provides health care access to immigrants.

Use interpreters' strengths. Hospital interpreters often share the culture of their patients and live in the same community. This makes interpreters a valuable bridge (or "cultural broker") between patients and hospital staff. Several hospitals are training

interpreters to do community outreach, help patients navigate the health care system, and facilitate conversations about medical decision making across cultures.

- In 1997, the interpreter services department at Caritas Good Samaritan Medical Center was expanded to include community outreach. Interpreters help to enroll patients in state-sponsored health insurance, visit elementary schools, local festivals, and churches, and give educational presentations.
- Harborview Medical Center combines the role of interpreter and community outreach worker in its Community House Calls Program. This program trains staff members in community health and interpretation so they can help patients navigate the health care system, by connecting patients with health care resources, coordinating their care, and providing them with support.
- Within San Francisco General Hospital's Immigrant and Refugee Clinic, on-site health workers have been trained in interpretation and community health. These staff members develop close relationships with patients and act as outreach and social workers—assisting with health system navigation, housing issues, social security, insurance issues, and other needs.

PROMISING PRACTICE #7

Provide Effective Language Assistance Services

Communication is important during every part of a hospital visit, from registration to

The interpreters have as much continuity with the patients as I do. They have really become integral to the care that is provided.

—Associate Medical Director for Ambulatory and Managed Care Systems, Harborview Hospital

discharge. Many patients are not able to communicate in English. Other patients, while fairly proficient in English, feel more comfortable communicating in their native languages. In some stressful situations, even patients who are fluent in English may forget how to communicate in anything but their native language. Having access to language services empowers patients and enables them to participate in their own care on an informed basis.

Often, initial conversations with hospital staff serve as the foundation for physician visits and other medical encounters. When language assistance is available during every stage of a hospital visit, it shows patients that the clinical encounter is not the only part of the health care process that is important.

While interpretation and translation services can be costly, the eight hospitals believe that failure to provide these services can cost even more. For example, the

hospitals have found that using qualified interpreters means they provide better-quality care, order fewer unnecessary tests, and most likely decrease medical errors and the potential for lawsuits.²⁴ Staff members repeatedly said they would refuse to go back to the “bad old days” before high-quality language services were available and when hospitals relied on ad-hoc interpretation by family members, even children, or unqualified, untrained staff members.

To provide the highest-quality language assistance services, these hospitals:

- make sure language assistance services are coordinated through a single hospital department and are the responsibility of a dedicated director;
- require interpreters to complete training and pass an assessment of their language and interpretation skills; and
- assess bilingual staff members on their language skills and train them on relevant communication skills.

Coordinate interpretation and translation services.

Hospitals that serve large populations with limited English proficiency typically create departments for interpretation and translation services and dedicate a staff person to direct these services. Hospitals that serve small populations with limited English proficiency may not need a department to house language assistance services, but they should still have a dedicated staff person directing them.

Healing is about the whole person, and a whole person needs to communicate. You can't be in medicine if don't have a human interaction, and if you don't have language you are really stymied.

—Pastoral Care, Woodhull Medical and Mental Health Center

Language assistance services include many complex tasks that should be managed by a single, dedicated staff member. This person is responsible for coordinating the different services, advocating for language assistance policies and training, defending the services against budget and staffing cuts, managing the budget, tracking and documenting the quality of services, assessing the changing needs of patients and staff members, supervising language assistance providers, and serving as the primary contact for patients and staff members.

- Caritas Good Samaritan Medical Center suggests that the head of interpreter services should be a director-level position to facilitate joint meetings and collaboration with other directors throughout the hospital.

- WakeMed Health and Hospitals finds that having a good director ensures that language assistance resources are used effectively.
- Sherman Hospital notes that finding the right person to lead an interpretation department can be difficult and suggests recruiting from other organizations. For example, if another hospital has a successful interpretation services department, one of the trained interpreters might be interested in advancing into a leadership role at another hospital.

According to several of the hospitals, a good language assistance services director:

- must be a strong advocate for established policies;
- must have the ability to persuade leaders and staff, at all levels of the organization, that everyone deserves equal care;
- must be able to provide rationale for new policies and procedures without creating adversaries;
- must work with clinicians to encourage acceptance of interpreter staff throughout the hospital; and
- should be someone with whom patient communities can identify and who understands the challenges of being an immigrant and not speaking English.

Caritas Good Samaritan Medical Center believes that, to be successful, interpreter services have to be dependable. If a nurse or physician calls and cannot get in touch with an interpreter or if they have to wait too long, they may never call again. This means it is critical for interpreters and clinical staff to communicate. For example, interpreters need to let clinical staff know when they will arrive and alert them if delays arise.

At Harborview Medical Center, the majority of interpreters recently moved from being contractors to regular employees. This has made it easier for the hospital to monitor their performance and provide training; it has also improved interpreters' response time. In addition, interpreters receive employee benefits and feel that they are part of the health care team.

To monitor quality and manage costs, University of Virginia Health Systems consolidated on-site interpretation, telephonic interpretation, document translation, and other language assistance services into one cost center. Among other benefits, this enables

the hospital to see if hiring interpreters is more cost-effective than contracting independent interpreters at \$50 per hour.

Assess and train interpreters. The seven hospitals with language assistance programs cautioned that just hiring bilingual or culturally diverse staff is not sufficient to meet the

Most people who do not work with interpreters really underestimate the skill level required to be good at the job.

—Director, Volunteer Services,
University of Virginia Health Systems

communication needs of patients. Interpretation requires training and assessment for specific skills. There is no guarantee that someone can do medical interpretation just because he or she grew up speaking a particular language. All seven of the organizations initially relied on untrained volunteers as interpreters, but none found this to be

a satisfactory solution for language assistance needs.

- Individuals who want to become interpreters at Woodhull Medical and Mental Health Center must pass a 45-minute language assessment conducted by the local college. They must also complete 40 hours of basic training and additional advanced training (five weeks of theory and five weeks of practical learning). All training is conducted on-site at the hospital and includes training on the Interpreter Code of Ethics developed by the National Council on Interpreting in Health Care.²⁵
- Medical staff interpreters at WakeMed Health and Hospitals are evaluated on written and oral language skills, knowledge of medical terminology, interpreter skills, and translation skills. Assessment and training is done in-house, based on examples from the Massachusetts Medical Interpreters Association and the National Council on Interpretation in Health Care. Interpreters are tested annually on the Interpreter Code of Ethics. The state of North Carolina does not certify interpreters. However, WakeMed Health and Hospitals is working with the local community college to develop an associate degree program that can be completed by medical interpreters.
- All Caritas Good Samaritan Medical Center interpreters, including those who work full time and those who work on a per-diem basis, are considered employees of the hospital and must go through standardized testing and training processes. Interpreters are tested prior to being hired and then annually on Massachusetts Medical Interpreters Association standards. They must complete interpreter training, including being mentored and shadowed. Each interpreter must attend two training sessions a year.

- All Sherman Hospital interpreters must pass a written language skills test several times: once when they apply, after they are trained, at some point within a 90-day probationary period, and periodically after that. Interpreters are also trained and tested on competencies that reflect situations when interpreters are most often used. In addition, interpreters must have a bachelor's degree and complete 40 hours of Bridging the Gap interpreter training, developed by the Cross Cultural Health Care Program.²⁶
- Interpreters at Harborview Medical Center are required to complete a training program, either Bridging the Gap or one of several local options. In Washington State, all medical interpreters must be certified by the state Department of Health.

Assess and train bilingual staff. Bilingual staff are assessed, and often trained, before they can provide services in languages other than English (and, in some cases, in English). In most cases, these staff members know exactly what tasks they are qualified and authorized to perform based on their language skills.

They [medical staff] know what really good medical interpretation feels like, and they know when they are not getting it.

—Pediatric Psychologist,
WakeMed Health and Hospitals

- Woodhull Medical and Mental Health Center maintains a list of bilingual staff members who have volunteered to use their language skills for interactions such as wayfinding and basic information gathering, which do not require a trained medical interpreter. These “language bank” volunteers are required to pass a 45-minute assessment conducted by the local college. These volunteers must also pass the college’s basic interpretation course (conducted on-site at the hospital).
- In addition to having trained medical interpreters on staff, WakeMed Health and Hospital qualifies other staff members to serve as bilingual providers or volunteer interpreters. Individuals who qualify to be bilingual providers can provide services in another language, but they cannot do medical interpretation or obtain informed consent unless they pass the required assessments. Volunteer interpreters are qualified to interpret at one of three skill levels in addition to their primary job function.
- Bilingual staff members at San Francisco General Hospital are tested and must demonstrate language competency to receive a small pay increase.

PROMISING PRACTICE #8

Be Aware of Low Health Literacy and Use Clear Language

Health literacy is an important consideration for all hospitals. Many patients have difficulty understanding complex or unfamiliar health information. This can be true for English-speaking and non-English-speaking patients alike—particularly if they are undergoing discomfort or stress.

Health literacy is a particularly important consideration for hospitals that care for patient populations likely to have limited health literacy skills. These include the elderly, certain racial and ethnic minorities, those with limited education, and immigrants.²⁷ All eight hospitals serve large patient populations that fall within these vulnerable groups. In many cases, patients who have limited English proficiency also have limited literacy skills. To address health literacy, staff members at these sites strive to communicate in clear and simple language, avoid medical jargon, and watch for signs of patient misunderstanding. Specifically, the hospitals recommend:

- carefully reviewing all hospital documents, educational materials, and signs to ensure they are written as clearly and understandably as possible; and
- incorporating the “teach back” method into hospital processes to make sure staff members remember to use it when they communicate with patients.

Carefully review documents, educational materials, and signs. Several of the hospitals are working to make documents, education materials, and signs as straightforward as possible. One recommended strategy is to have patients or hospital volunteers read drafts of the documents and provide feedback.

- Several sites in the Iowa Health System note that it is important to work closely with members of the marketing department (or community relations) to ensure they understand the importance of creating clear, simple messages.
- Translators at several hospitals (Caritas Good Samaritan Medical Center, Sherman Hospital, and WakeMed Health and Hospitals) reported commonly finding sections of English-language documents that are difficult to understand. In most cases, the English versions are then edited to make them clearer.

The best way to check if information is clear is to have patients read it. This is true whether the information is in English or another language.

- Every hospital in the Iowa Health System is encouraged to seek individuals in its community who will volunteer to review written documents for clarity. They seek volunteers and patients who have both limited and good literacy skills.
- When Caritas Good Samaritan’s interpretation staff translated a diabetes education booklet, they asked three patients from three different countries to review it. Two patients were diabetic and one was not.
- The manager of interpretation services at Sherman Hospital noted that, while information needs to be simple enough for patients to understand, it also needs to be specific enough to convey the right idea. For example, if clinicians use the term “X ray” for any kind of medical imaging exam, subsequent doctors taking a history from patients might not be able to tell if they had an ultrasound, CT Scan, MRI, or regular X ray.

Hospitals have taken different approaches to making sure patients understand informed consent discussions and documentation.

- For example, the Iowa Health System greatly simplified its surgical consent form. Leaders there believe that it is better to have a form that most people can read than a complex form that most people do not read or understand. The current form is written in plain language and encourages interaction, for example by asking patients to stop the process if they do not understand something. When necessary, nursing staff can easily read the form to patients. Nursing staff ask patients to “explain back” what they have been told about their surgery and transcribe their responses in the form.
- On the other hand, at University of Virginia Health Systems, the surgical consent form is written at the level of a junior in college. The rationale is that even when forms are written at the fifth-grade level, some patients might not have the literacy or health literacy skills, or the desire, to read and understand them.²⁸ Furthermore, hospital leaders and lawyers believe that the form should be used as a guide for an informed consent conversation, not as a stand-alone document.

Working with interpreters has helped us realize that we often don’t communicate clearly enough with English-speaking patients.

—Human Resources Director,
Sherman Hospital

Several hospitals are struggling to decide whether to translate informed consent forms. Some fear that if the forms are translated, staff members will be less likely to call an interpreter to assist with the informed consent discussion (Caritas Good Samaritan Medical Center, Sherman Hospital, and Harborview Medical Center).

Informed consent is a process, not a form.

—Director of Risk Management,
Iowa Health System

Incorporate “teach back” into processes. In addition to considering patient health literacy for written communication, it is important to consider health literacy during conversations about health information.²⁹ The “teach back” method, in which health providers ask patients to recount information and instructions they have been given, seems to help patients understand and remember information.³⁰ To make the “teach back” method part of every health care encounter, some hospitals are building it into commonly used forms and processes.

- At University of Virginia Health Systems, all surgery patients receive a phone call from Pre-anesthesia Evaluation and Testing Department staff on the afternoon before they come in. The format for this phone call has been changed to incorporate the “teach back” method. Instead of simply confirming that patients know how to prepare, staff now ask them to explain how they are preparing for their surgery.
- As discussed above, Iowa Health System’s surgical consent forms encourage patients to explain back what they have been told about their surgery.

PROMISING PRACTICE #9

Evaluate Organizational Performance Over Time

All eight of the hospitals have strategies for evaluating performance. These generally include measures of patient perception and staff satisfaction as well as assessments of specific services and interventions. While it is important to evaluate performance, it is even more important to track changes in performance by conducting periodic evaluations over time. Periodic evaluations help hospitals determine whether trainings, new procedures, and other interventions have a positive or negative impact on performance.

For communication performance, these eight hospitals use several methods of evaluation. They measure patient perceptions and knowledge, staff satisfaction and performance, the amount and subject of feedback, appropriate use of available services, and how often patient and staff requests for communication services are met. These evaluations help hospitals decide how to allocate funding for communication projects and where additional training and resources are needed.

Specifically, the eight hospitals have found that regular performance evaluation helps them to:

- identify and document areas in which individual staff members and organizations as a whole are communicating well and areas in need of improvement;
- make informed judgments about which aspects of staff and organizational communication are associated with improved quality, safety, and health outcomes; and
- prove the benefits of communication initiatives and justify ongoing resource allocation for these programs.

Report and track communication problems. Several hospitals encourage staff members to document when communication problems occur, such as when interpreters are needed but not available, or when patient misunderstandings lead to potential or actual adverse events.

Patients and staff members should be encouraged to provide feedback and submit complaints when their communication needs are not met. When an organization starts hearing complaints from workforce members and patients about an inability to communicate (e.g., to take medical histories or provide instructions) it needs to take action. Patients and staff members may not want to criticize a department or person that is working very hard, but such complaints provide valuable documentation to take to leadership as a rationale for providing the resources needed.

- The leaders of Community Outreach and Interpreter Services at Caritas Good Samaritan urge patients and staff members to complain to the hospital administration if the level of community outreach or interpretation services is ever inadequate.
- As part of a grievance review, Woodhull Medical and Mental Health Center found that assigning managers to different aspects of the process made it possible to collect and aggregate grievance data and understand the nature of complaints for use in future improvements.
- Prior to having an interpreter program, staff members in the University of Virginia Health Systems' volunteer office tracked how often they received requests for interpreters from departments. They also tracked how often they were able to provide a volunteer interpreter. Using the current computer registration system, the hospital is now able to track how often interpreters are needed and how often they are provided.

Hospital leaders doesn't need to hear how well we are providing services; they need to hear how often patients are not getting critical information about their health when interpreters are not available.

—Director of Volunteer Services,
University of Virginia Health Systems

Link communication performance to outcome indicators. Several of the eight hospitals are developing strategies for tracking the communication performance of staff and interpreters and linking performance to cost savings. Few have drawn connections between improved communication and health outcomes. Health system leaders have suggested that, ideally, all hospitals should track medical outcomes according to patient race, ethnicity, and primary language. As noted under promising practice #2, a few of the eight

hospitals have taken steps to improve and monitor the quality of the data being collected from their patients, especially language and other communication needs, in an effort to document when and how well the patients needs are being met.

Program evaluation, often including cost and benefit calculations, is a key component of all of the hospitals' initiatives, including those for improving communication. Because the hospitals face budget constraints, proving the clinical and business merits of programs for effective communication with vulnerable populations is a high priority.

Most of the hospitals conduct patient and staff satisfaction surveys, either in-house or through a third-party evaluator. In some cases the hospitals have customized the surveys to include questions about how well physicians, nurses, and other staff members communicate. The hospitals that provide language assistance services also commonly track information such as requests for interpreters, number and type of interpreter encounters, timing associated with interpreter encounters, and use of telephonic interpretation. However, in these eight hospitals, communication performance and use of interpreters is not yet linked to many measures of health care outcomes.

Many of these hospitals are considering what outcome measures should be linked to communication interventions, such as use of an interpreter or the "teach back" method. Measures being studied include:

- adherence to medication and treatment regimens;
- length of stay;
- inappropriate visits to the emergency department;
- re-hospitalizations;
- number and rate of appropriate follow-up visits;

- patient satisfaction;
- clinical staff satisfaction;
- non-clinical staff satisfaction;
- percent of patients who are aware of scheduled surgery when they receive a reminder call; and
- improvements in laboratory values, such as hemoglobin A1c levels.

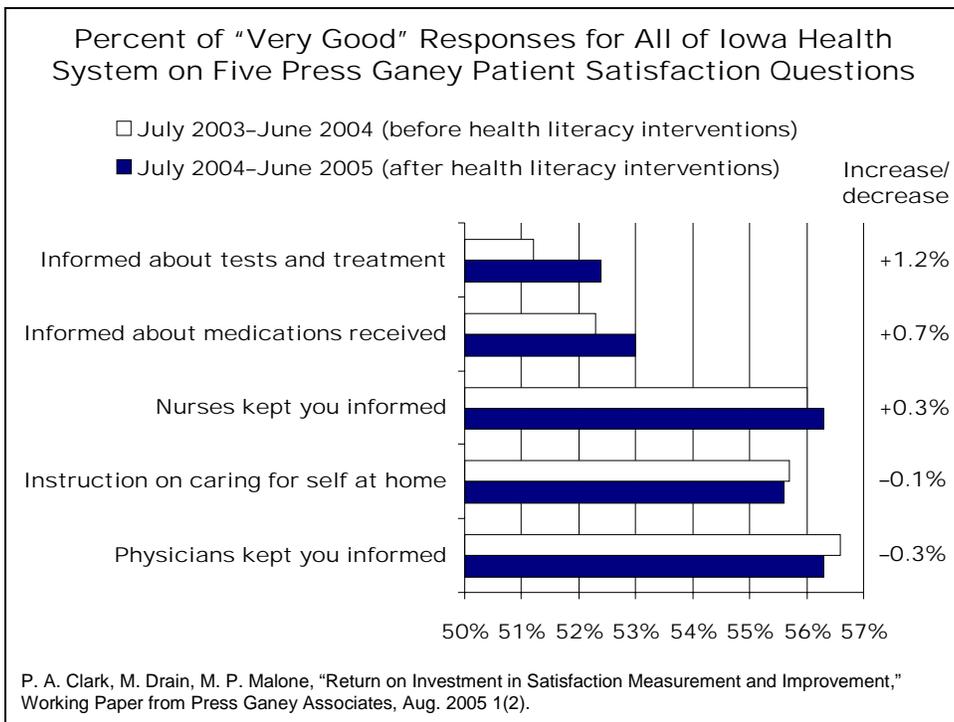
Several hospitals recognize a need to better understand when adverse or sentinel events happen as a result of miscommunication.

- Staff at Harborview Medical Center note that there is no way to indicate “communication with patients” as the root cause on incident reports. This can lead to underreporting of communication problems with all patients, especially patients with limited English proficiency.
- San Francisco General Hospital staff perceive a need for a standard taxonomy for reporting communication errors between physicians and patients. This is especially true for outpatient communication lapses.
- The Sherman Hospital Cross-Cultural Communications Department is in the process of developing performance indicators that can link communication problems or lack of communication to adverse clinical events. For each adverse event, staff are asked to indicate problems in specific areas of communication, such as during consent or discharge instructions, as well as other standard process and outcomes measures.

Hospitals are evaluating and proving the benefits of communication efforts in the following ways:

- Iowa Health System is monitoring the proportion of “very good” responses to five items related to health literacy on the Press Ganey surveys used by the system to monitor patient satisfaction.³¹
 - These items include: “nurses kept you informed,” “physicians kept you informed,” “informed about tests and treatment,” “informed about medications received,” and “instruction on caring for self at home.”

- Patient satisfaction results were compared between July 2003–June 2004 (before health literacy interventions) and July 2004–June 2005 (after health literacy interventions).
- For three questions, average “very good” percentages across the system increased by 0.3 percentage points (nurses kept you informed), 0.7 percentage points (informed about medications received), and 1.2 percentage points (informed about tests and treatment) (see figure).
- Press Ganey satisfaction data are difficult to consistently affect from year to year, making even small improvements noteworthy.³²



- San Francisco General Hospital has found that using visual aids such as Visual Medical Schedules improves concordance rates between physicians and patients about Warfarin (Coumadin) regimens (see table).³³ Concordance rates were based on how often patients’ description of their weekly regimen matched how physicians reported the regimen in the patients’ records.
 - These verbal adherence assessments were done by bilingual staff members. This means that, in practice, concordance may actually be lower when communication takes place between patients and staff members who do not speak the same language.

Concordance Rates Between Physicians and Patients
About Medication Regimens

	Concordance rate when patients verbally describe medication regimen	Concordance rate when patients visually identify medication regimen
Overall concordance	50%	66%
By language		
Cantonese	38%	74%
Spanish	44%	62%
English	56%	66%
By health literacy level		
Inadequate	42%	57%
Marginal	61%	65%
Adequate	64%	74%

D. Schillinger, E. L. Machtiger, F. Wang et al., “Language, Literacy, and Communication Regarding Medication in an Anticoagulation Clinic: Are Pictures Better Than Words?” In *Advances in Patient Safety: From Research to Implementation, Volume 2* (Rockville, Md.: Agency for Healthcare Research and Quality, 2005).

Effective communication about medication regimens and adherence to regimens is crucial because it drives future medication counseling and clinical management. In San Francisco General’s study, discordance about medication regimens is associated with poor anticoagulant outcomes.³⁴ This means that improving concordance by using Visual Medical Schedules to supplement explanations about medication regimens might improve health outcomes and patient safety.

- University of Virginia Health System has found that using the “teach back” method has reduced the number of surgeries delayed or cancelled because patients did not arrive on time or at all, arrived without proper preparation, or arrived without properly understanding their surgery.
 - Nursing staff incorporated the “teach back” method into the preoperative visit. After giving instructions, staff members now ask the patients to explain their surgery and each of the instructions.
 - If patients are unclear about their surgery or how to prepare for it, further clarification can be provided until the patient can repeat the information correctly.
 - As described above, all surgery patients also receive a phone call from the Pre-anesthesia Evaluation and Testing Department the afternoon before they come in for surgery.
 - Instead of using these phone calls to have patients confirm they know how to prepare for surgery, staff members now ask patients to explain how they are preparing.

- After four months, these simple changes reduced the surgical cancellation delay rate from 8 percent to 0.8 percent.
- This resulted in significant savings, because surgery delays and cancellations cost the hospital \$56 per minute.³⁵

BARRIERS AND SOLUTIONS

The hospitals with long-standing communication programs as well as those with more recently initiated programs encountered barriers during program initiation or expansion. Most of these were barriers that organizations regularly encounter when embarking on new initiatives. Common barriers include: convincing leadership of a program's value, persuading staff members to participate, finding qualified program staff, evaluating the programs, and proving their value over time. The hospitals found that, with time and persistence, committed staff can overcome the barriers, no matter how formidable they might seem.

Convincing Leadership

In a few of the hospitals, patient-centered care and communication programs are initiated by leaders. In other cases, staff champions have to craft arguments to convince leaders of the value of communication programs, especially those aimed at making communication across cultures, languages, and literacy levels patient-centered and effective.

The right argument. Some hospital leaders are hesitant to develop cross-cultural communication, language assistance, and health literacy programs. They might worry that such programs will attract patients who do not have insurance and will thus be a financial burden on the hospital. Some staff members have found a number of arguments to respond to such concerns.

- It is increasingly common for health care organizations to care for patients from diverse backgrounds who may not be proficient in English and/or have limited health literacy skills.
- Ineffective communication with these patients, or any patient population, can lead to misunderstandings about health histories, consent, medication and treatment instructions, or other issues. This can lead to problems with quality, safety, and adherence.
- Developing communication initiatives across an organization can help leaders manage expenditures, minimize losses, provide higher-quality care, and improve satisfaction for all patients.

Persistence and data. Clinical staff are often the first to notice when communication with patients becomes difficult. In one case, a Spanish-speaking physician noticed that the hospital's volunteer interpreters sometimes injected inappropriate personal judgments into their interpretations between physicians and patients.

- This physician persistently expressed his concerns to the hospital's chief operating officer and a senior vice president.
- He supplemented his observations with data on the increasing number of Spanish-speaking patients delivering babies at the hospital.
- Together, this persistence and data convinced the leaders to develop a formal language assistance program.

The right time and right audience. Leaders at one hospital were persuaded to develop a language assistance and cross-cultural communication program when the topic was brought up at a management retreat.

- One physician stood up and described the communication challenges he was experiencing and the need for stronger language assistance services.
- In the presence of the hospital's clinical leaders, board members, and chief executive officer, other staff members testified to having similar experiences.
- This motivated hospital leaders to focus on how they provided language assistance. The leaders did not want to come to the next retreat without a progress report.

Convincing and Training Staff Members

Once a patient-centered communication program or initiative is in development, its success depends on the participation of staff members across the organization. This means informing them about the program, convincing them of its value, and training them to do what the program requires.

Proving need and value. Some hospitals have found that staff members do not understand the impact of limited health literacy on care and do not accept that many of their patients may have limited health literacy skills.

- One hospital did a small research project to see if residents could tell which patients had limited health literacy skills. The researchers found that the residents were wrong most of the time, both overestimating and underestimating patients' skills.

- Other hospitals identified a few patients who were willing to share stories about their experiences in the health care system. Staff members are routinely surprised at the challenges patients experience and the lengths they go to disguise their limited literacy and health literacy skills.
- Once staff members understand the prevalence and impact of limited health literacy skills, especially among their own patient populations, they often become advocates for communication programs.

Finding time. It is often difficult to find time on staff training schedules to introduce new programs. In addition, staff members may be reluctant to change their communication strategies when they feel the new strategies will take additional time.

- Staff training should be introduced gradually, offered at flexible times and in various formats, and regularly reinforced.
- Introduction of new programs should be integrated into several meetings and training sessions. This will provide opportunities to reach all staff members, who may not even realize they are being trained. For example, one hospital provided instructions on how to work with interpreters as part of training on how to use the phone system and access telephonic interpretation.

In some cases, staff members were reluctant to use the “teach back” method. They felt it would take too long to ask patients to explain instructions.

- Several hospitals started by asking a few physicians to test the method with a small number of patients. This allowed them to develop a routine and evaluate the method’s benefits. These physicians quickly became advocates for the use of “teach back” to help patients understand information and instructions.
- Another hospital noted that the “teach back” method has become such a routine that it does not add any additional time to outpatient visits. When one center’s staff members began using the “teach back” method they saw a total of 70 to 90 outpatients per day; a year later they now see 90 to 100 outpatients per day.

Finding Qualified Program Staff

It is challenging to find staff members who are qualified to work as interpreters, cultural brokers, outreach workers, health literacy advocates, or other roles. Individuals with these skills are in high demand and hospitals often do not have the resources to provide salaries that are competitive with other types of businesses.

Most hospitals overcome this by working with the community and within the hospital to find individuals who want to work in health care and are willing to be trained in the skills they need.

- At least two of the hospitals are working with local community colleges to develop curricula to train staff and community members who are interested in improving their communication skills, working as interpreters, or advancing their careers.
- Several hospitals have developed close relationships with other local groups that work to train and place community members in jobs throughout the community.
- In some cases, the hospitals have had to force staff members to work on communication programs. While staff members may not at first be enthusiastic about the programs, some may develop a passion for improving communication as they work with patients and learn to appreciate the importance of effective, patient-centered communication.
- Some hospitals are finding ways to take advantage of staff members' strengths, especially when work tasks overlap. For example, community outreach workers are being trained as interpreters, interpreters are being trained as financial counselors, and health educators and bilingual workforce members are being trained to use their language skills for their jobs.

Evaluating Programs and Proving Their Value

Most hospitals struggle to find ways to evaluate their programs and quantitatively demonstrate their value. In many cases, this is critical to sustaining and expanding the programs over time.

Program champions are constantly working to gather the data needed to track program success. In several cases, champions have to rely on other departments in the hospital—such as information technology, risk management, or quality improvement—to develop systems for gathering, tracking, and evaluating program data. These departments are often busy and may not have the same priorities as the staff members implementing the programs.

The primary way program staff have addressed these challenges is by linking communication programs with other initiatives taking place in the organization, such as patient safety, quality improvement, and risk management.

- This means getting staff members from departments across the organization involved in communication programs early.
- Staff members can then work together to demonstrate how improvements in communication benefit patients and contribute to other important initiatives.
- This spreads the focus on improving communication across the organization and builds awareness and support among staff members and leaders.

In most cases, staff members start small and use data they already collect to track communication performance. This often includes evaluating the reasons for patient complaints and other feedback, reviewing patient satisfaction data, looking at how often interpreters respond to requests, and other simple, low-cost indicators of communication performance. Once these data begin to demonstrate improvements, staff members often request assistance to conduct additional evaluations.

SITE VISIT SUMMARIES

Caritas Good Samaritan Medical Center

In 1993, Caritas Good Samaritan Medical Center began providing interpretation services in response to rapidly changing patient demographics. In 1997, the program was expanded to include community outreach and is now referred to as the Community Outreach and Interpreter Services Department (COIS).

In 2000, one of the large physician groups affiliated with Caritas Good Samaritan changed its affiliation to a local competitor. This left Caritas Good Samaritan with few doctors and on the verge of closing. Even with the threat of closure, Caritas Good Samaritan's administrators continued the practice of having hospital interpreters accompany patients to physician visits. This was significant because the patients were being referred to the hospital's competitor. The patients who received these community outreach and interpretation services began to switch to doctors who still worked with Caritas Good Samaritan. These loyal patients went to the Massachusetts statehouse to picket on behalf of the hospital and helped to keep it open.

Integrate communication initiatives. At Caritas Good Samaritan the outreach and interpretation staff are well integrated and visible within the organization. Visibility should be a consideration when deciding who the community outreach and interpreter services staff report to within a hospital. COIS staff originally reported to the marketing and philanthropy area. They are now supervised by the vice president of nursing and patient services. With this change, the COIS director began to participate in weekly clinical

leadership meetings and become more visible to clinical areas. The COIS director and staff also serve on several other hospital committees, including ethics, Joint Commission, patient tracer, patient education, and community benefits.

Being moved to an office right off of the hospital lobby has also helped make the COIS department more visible. It provides an easy starting point for patients who may have a hard time just coming in the door of a hospital.

Use data to build support. Many of the registration staff remember a time when it was illegal to ask patients about their race and ethnicity. Several are still reluctant to ask patients for this information. Staff members currently ask patients, “What race do you identify with?” Staff members can point to a list of race and ethnicity options (Office of Management and Budget categories) that is posted in relevant languages. Caritas Good Samaritan trained registration and patient access staff in ways to ask this question. As part of the training, staff members pay attention to how they and their co-workers ask registration questions and provide each other with feedback. If people recognize when something they said could have been said better, they can make conscious improvements. Training also prepares staff members to respond to patient questions and concerns.

Train staff. All new staff are educated about the COIS department during monthly orientations. New or refresher information is also provided periodically to current staff members. COIS staff constantly reinforce the hospital’s policies on not using minors and discouraging use of family members as interpreters.

Since the interpreter services began, clinical staff have been told that interpreters can only convey exactly what is said during the course of a conversation—they cannot provide patient education without a doctor or nurse present. Interpreters must periodically remind staff members of the hospital’s expectations for who can interpret and what an interpreter can and cannot do.

Watch for communication problems. When communication problems are identified, the director of the COIS department addresses them by first contacting the subject and having a one-on-one conversation. If there is a recurring problem, she involves the person’s manager. If the problem is prevalent in an area or department, she attends a meeting of that area and discusses the problem.

Most physicians are glad interpreters are available as a resource. However, a few physicians do not want to work with interpreters and insist on talking to patients only in

English or try to get by using only their own rudimentary language skills. COIS staff never refuse to interpret for patients when they visit these physicians. Instead, they work with them as best they can. In many cases, patients who need language assistance decide on their own to switch to a physician who is willing to work with COIS.

Educate patients. Interpreters visit every limited English proficient inpatient twice each day (average 10 to 12 patients). When possible, the interpreters bring a nurse with them. This gives nurses a chance to communicate with their patients at least once per shift.

Recognize the importance of culture. Staff members at Caritas Good Samaritan feel that, in some cases, the role of COIS staff as cultural brokers is even more important than their role as interpreters. Staff members note that, before the COIS department was created, cultural misunderstandings regularly escalated into major problems. After seeing how quickly the COIS staff resolve such misunderstandings, staff (and specifically intensive care unit or cardiac care unit staff) began involving them earlier. There has been a significant shift in hospital culture. Clinical staff now automatically call the COIS department if they suspect an issue results from a language barrier or cultural miscommunication.

Use interpreters' strengths. Caritas Good Samaritan's COIS staff are trained as MassHealth (the state's Medicaid program) and "free care" (uncompensated care pool) counselors. Because patients trust the COIS staff, they often tell them when they do not have health insurance. With the counselor training, COIS staff can work with these patients and enroll them in state insurance programs. COIS has a process for identifying and following-up with patients who have applied for insurance from the state. This process helps generate money for the hospital, because services can be reimbursed for patients who might not have been able to pay.

Coordinate interpretation and translation services. The COIS department has 7.2 full-time equivalents (FTEs) available to hire staff and 20 employees. Many of these employees are paid on a per-diem basis and provide interpretation as needed. Interpreters can be reached by calling the COIS office or using a central pager number. They are available 24 hours a day, seven days a week. One interpreter serves as a dispatcher and answers calls.

The COIS department provides scheduled and emergency interpretation within the hospital and for local physician groups. The physicians can be employed by the

hospital, affiliated with the hospital, or, if requested by a patient, affiliated with other hospitals.

Physician visits. The hospital's interpretation policy states that patients are provided with an interpreter for their first physician appointment and one follow-up visit. Although COIS staff members are busy, they have never denied someone an interpreter for additional physician visits past the follow-up. The hospital provides interpreters for about 1,300 offices visits per year. Each averages about two hours, including the interpreter's travel time and the visit. The farthest physician office is about 10 minutes away from the hospital.

Interpreter Services Assessment Form. This form—printed on red paper to stand out from other forms—is included in the medical record of every patient who requires an interpreter. It notes the language or languages patients speak and whether they can read in them, and states whether patients can speak any English. It also briefly outlines instructions for contacting and using interpreters.

Informed Consent Forms. The hospital struggled to decide whether the English version of their consent for surgery form should be fully translated, or if only the most important points should be translated. The final decision was to create informed consent forms with the complete English version on one side of the form and a fully translated version on the reverse side. This is done for all of the hospital's relevant languages. Patients sign the front (English side) of the form, where a note in their language directs them to read the back. Interpreters also sign the form.

Interpreter Encounter Form. This form is included in the patient record. For each date of service, interpreters document when they were present to interpret. If a patient prefers to use their own interpreter, he or she must sign this form and list the name and relationship of the person they designate as their interpreter.

Translated Documents. Translated documents are color-coded by language—Portuguese, Cape Verdean, Haitian Creole, and Spanish—to easily identify the language.

Assess and train interpreters. All interpreters are employees of the hospital and go through the same testing and training processes. As employees, new interpreters participate in all of the hospital's new employee orientation activities. This helps the interpreters become integrated into the organization and helps them feel they are part of a health care team. Interpreters are tested annually and prior to being hired on Massachusetts Medical

Interpreters Association standards. The COIS director conducts the tests. For languages she does not speak, the tests are taped and sent out for review.

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Harborview Medical Center

Harborview Medical Center is owned by King County and managed under contract by the University of Washington. All hospital staff are employees of the university. Harborview Medical Center is a comprehensive health care facility dedicated to the control of illness and promotion and restoration of health. Its primary mission is to provide and teach exemplary patient care and to provide health care for those patients King County is obligated to serve. Harborview Medical Center, located in downtown Seattle, is the local county hospital and the Level I trauma center for a four-state region. In 2004, Harborview served patients who spoke 69 different languages and dialects.

Make leadership support visible. Harborview employees highlight that the hospital has “mission populations.” The hospital’s mission explicitly lists several priority populations, including the non-English-speaking poor, indigents without third-party coverage, and others. Having these vulnerable populations documented in the hospital’s mission gives staff members confidence that their efforts to advocate on behalf of (champion) innovative programs to improve care for these populations will have administration support.

Harborview’s commitment to effective communication originated with specific physician champions. Several respected physicians are seen as role models for their professional behavior and insistence that all patients who come to Harborview are treated with respect.

Assess the needs of patients and staff. Patients’ language, race, and ethnicity are entered into the hospital-wide data system (EPIC) at registration. Patients are asked to identify their primary language and say what ethnicity they consider themselves to be. Registration staff identify whether patients need interpreters, either by asking them or judging how they respond to questions. If their language needs change or become apparent later in the process, the language field can be edited.

Engage communities. Harborview's Community House Calls program uses a navigator model to build relationships among the hospital, patients, Harborview practitioners, and community. Case managers assist patients and families in the hospital and in their homes. The services they provide include health system navigation, advocacy, case management, health education, interpretation at hospital visits, and cultural mediation. They can also provide assistance with health insurance, social services, schools, immigration, and transportation. Case managers help physicians by providing cultural consultation and presentations on health beliefs, traditional health practices, and end-of-life issues. Case managers work in Harborview's communities to identify and remove barriers to care and provide information. Community House Calls are provided in a few priority languages, including Amharic, Cambodian, Spanish, Somali, Tigrinya, and Vietnamese. Groups more familiar with Western health care are not included in the program.

Work closely with a community advisory board. The Community House Calls Program has its own Community Advisory Board. When the program began, volunteers from local organizations were invited to attend. The goals of this board include building relationships with communities, learning from communities, and providing a forum in which the hospital can receive feedback from local communities.

Recruit and retain diverse staff. Harborview believes its workforce should resemble its communities as much as possible. Hiring workforce members from local communities is especially important to the International Medicine Clinic and the Community House Calls Program. When possible, staff are bilingual and bicultural. Bilingual employees are paid a 5 percent differential if they use language skills two or more hours per week. Many patients come to feel so welcome in the hospital they want to work there. Harborview has volunteer opportunities for patients and intends to create more career paths for them.

Appropriate supervision and management can help hospitals integrate employees working in the community (e.g., Community House Calls case managers) into the hospital structure. In addition to training, hospital staff working in the community need a hospital contact to provide support and resources. The interpreters and case managers working in the community cannot always provide feedback to clinicians or organization leadership, but an appropriate manager can.

Train staff. Harborview recognizes the importance of training staff to respect individuals and their cultures. The hospital has found that training works best when it is tied to a clinical subject that staff members recognize, and is tailored to the hospital and its

patients. For example, practitioners are more attentive if training incorporates real-life stories from interpreters and patients. Harborview also suggests linking training to patient safety and health disparities and adjusting training based on participant feedback. In addition, Harborview promotes a team approach to cultural competence. Staff are encouraged to consult with colleagues in social work, interpretation services, spiritual care, or other areas when communication issues arise.

Recognize the importance of culture. Harborview is committed to disaster preparation and serves as the only Level I trauma center in its region. The hospital recognizes that interpretation and cultural brokerage are critical for disaster preparation. Harborview is exploring the meaning of disaster from different cultural perspectives. Beginning a dialogue on basic concepts, such as quarantine, can help build relationships and trust and prepare communities in the event of a disaster.

Ethnomed. Harborview created the Ethnomed Web site to document its experiences caring for patients from a range of cultural backgrounds. The site provides community profiles and educational materials for health care professionals. Most of the materials focus on clinical issues faced by the populations directly served by Harborview. In addition, forms, educational materials, and presentations are available in various languages. The site is not viewed as a clearinghouse for information, but instead as a work in progress that is always being updated to reflect new information about patient groups.

Create a welcoming environment. Harborview's International Medicine Clinic provides a range of health care services to refugee and immigrant patients who require cultural brokerage as well as interpretation. Clinic staff work closely with the Community House Calls Program case managers. The clinic uses a group-practice model with internal medicine faculty. Interpreters are assigned to the clinic for blocks of time and many staff members are bilingual and bicultural.

Coordinate interpretation and translation services. Harborview has developed an algorithm to help staff members use interpreters correctly. This algorithm includes three levels: encounters that can be done using telephonic interpretation; encounters that should be done using in-person interpreters, but can be done with telephonic interpretation, depending on availability; and encounters that require an in-person interpreter.

Harborview has a policy stating that a patient's children and family members should not serve as interpreters. Patients who do not want to use the hospital's interpreters or wish to have a family member or friend interpret for them must sign a legal waiver.

A practitioner can override this waiver and bring in an interpreter if they are uncomfortable communicating without one.

Translations. Harborview's process improvement group recently performed an inventory of translated materials. It also created a translation process and administrative guidelines for translating documents. The guidelines outlining whether documents need to be translated take into account community literacy levels. The issue of whether to translate consent forms is still being considered. The most common consents will probably be translated.

Assess and train interpreters. Medical interpreters in Washington must be certified by the state Department of Health. At Harborview, interpreters must complete Bridging the Gap training or another program. The Community House Calls case managers receive interpreter and community health worker training.

Within the past six years, most Harborview interpreters have changed from contractors to hospital employees. This shift resulted from a lawsuit charging that contract interpreters were being used as employees without the benefits of employment. With most interpreters as employees, it is now easier for Harborview to monitor the quality of interpreters and provide training. Requests for interpreters are fulfilled more quickly and employee relations are better.

Evaluate organizational performance over time. The interpretation services department participates in Harborview's hospital-wide process improvement program. This program tracks improvement initiatives throughout the year and requires programs to assess performance in four areas—patient and staff satisfaction, operational efficiency, clinical outcomes, and cost effectiveness. Patient feedback comes from surveys, focus groups, and one-on-one interviews. The hospital's biannual outpatient satisfaction survey is done on-site so that interpreters can assist patients with the questions. Staff are also surveyed on the efficiency of interpretation services and adjustments are made based on this feedback.

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Iowa Health System

Iowa Health System was created in 1993. It operates health care facilities in seven Iowa communities and Rock Island, Illinois; supports a system of rural hospitals in 14 Iowa communities; and partners with physicians and clinics in more than 80 communities in Iowa, western Illinois, and eastern Nebraska. Its mission is to improve the health of the people and communities of Iowa.

In 2003, Iowa Health System identified several topics for system-wide quality and safety improvements. Some topics were related to specific diseases and others were overarching concepts. Health literacy was identified as one of two overarching concepts.³⁶ Leaders within the system believed that improvements in health literacy could improve the safety and quality of care.

Iowa Health System began its health literacy work by asking senior leaders at each of its affiliates to assemble a health literacy team. The teams came together for an initial learning session, during which health literacy was discussed and potential interventions were presented. Each team was asked to choose at least one health literacy intervention to develop, test, and use within their institution.

Integrate communication initiatives. Because each affiliate has its own communities and strengths, Iowa Health often provides leadership and support at the system level but then encourages affiliates to implement and customize interventions to meet their own needs. Iowa Health uses the IHI model for improvement and collaborative learning. Affiliates note that this allows the spark to come from the system and filter across all levels, as teams are brought together to learn. The support of senior leaders at the affiliate level is an important element of this process.

Integrate communication initiatives. Iowa Health System has found that initiatives should not be forced by a management team. Instead, physicians, nurses, educators, and other key workforce members should be involved in their development and implementation. This ensures that initiatives are useful and have internal support. Within each of Iowa's affiliates, team configuration depends on the projects, but is always cross-disciplinary and includes clinical staff and, sometimes, marketing. Affiliates note the importance of working with marketing departments to incorporate plain language principles into written materials.

Use data to build support. Most Iowa affiliates view the collection of data from and about patients as an eye-opening experience. Strategies affiliates use for data collection

include: medication reconciliation studies, follow-up phone calls with patients to see if they understand self-management guidance, interviews with patients about navigating the health care system, interviews with workforce members, and analysis of forms and materials, especially by having patients review them and point out difficult words or phrasing.

All affiliates use online literacy estimates for their city or county to demonstrate local literacy levels.³⁷ This, together with personal stories about communication struggles from patients and staff members, provides evidence that health literacy is a real issue for each hospital.

Iowa Health System has also developed and integrated questions about patients' learning styles and reading comfort levels into the affiliates' admission protocols. On admission, patients are asked about their preferred learning style and their happiness with how well they read.

Collaborate with community organizations. Iowa Health System has an active relationship with the New Readers of Iowa, an adult learner organization that has recently begun addressing health literacy as well as adult literacy. In 2003, Iowa Health System staff attended the New Readers' annual meeting. In 2004, Iowa Health System staff brought several hospital documents to New Readers members. Their focused, candid critiques of the documents gave the health literacy teams important insights and reinforced for them the importance of obtaining patient feedback when reviewing documents. As part of a review process, each of the Iowa Health System sites identifies individuals, either new readers or patients, who are willing to review documents for clarity.

Train staff. One affiliate began its work on health literacy as part of an organization-wide patient safety initiative. The first step was to invite all staff members who might develop written materials to serve on a committee. This committee was charged with raising awareness about health literacy and developing all educational materials at the seventh- to eighth-grade reading level or below. To raise awareness, copies of the American Medical Association Foundation's health literacy video were shown to 80 percent of the workforce, including secretarial, billing, and clinical staff.

Several affiliates use the American Medical Association Foundation's video, *Help Your Patients Understand*, or other resources to introduce the importance of health literacy during orientation for all employees. Iowa Health System also developed a computer-based training module on health literacy. Clinical staff at all sites are required to complete this module; some sites are requiring that all employees complete the module.

Iowa Health System encourages their affiliates to train nurses and physicians to recognize signs of low literacy or health literacy. For example, if patients leave sections of forms blank, staff may need to review them to ensure they were not left blank because the patients could not read them. Some affiliates are training physicians and nurses to use the “teach back” or “show me” method. Most start small and ask only a few physicians and nurses to use “teach back” with the last patient before lunch, or with the last patient of the day.

Some affiliates find that new staff members from academic backgrounds also need training on how to make patient education clear and simple. This includes educating workforce members on patient demographics.

Use patients’ experiences. The Iowa affiliates have found that involving patients in health literacy initiatives builds passion among the workforce. Hospital staff may not understand the magnitude of health literacy problems until they see data from their own hospital and hear from patients in their own community.

Create a welcoming environment. Iowa Health System’s affiliates have taken several steps to make their hospital environments more welcoming for patients with limited health literacy skills. They have made patient education brochures clearer, displayed adult literacy brochures, and created color-coded directories to make it easier for patients to find their way around the hospitals.

To encourage patient understanding and questions, Iowa Health affiliates are also pilot-testing the AskMe3 tool, designed to improve health communication between patients and providers (www.AskMe3.org). AskMe3 questions have been added to patient admission packets and displayed in patient rooms. AskMe3 posters have also been displayed in units across several affiliates. Training to encourage staff to promote the AskMe3 questions is ongoing and patients are beginning to use the questions as they learn about them.

Carefully review documents, educational materials, and signs. The Iowa Health System as a whole and the individual affiliates are in the process of reviewing forms and educational documents and rewriting them at more appropriate reading levels. This is being done slowly over time, since there are thousands of documents that need review.

One affiliate has an active patient education committee that includes one member from each department. This hospital adopted a policy that stated all new materials must be

approved by the committee. Existing materials are being reviewed a few at a time. Newly purchased materials must be written at a particular reading level.

Another affiliate delegated the task of reviewing educational materials to its forms committee. This committee had an existing structure that allowed it to begin reviewing and revising materials; they hope to revise all existing materials within two years.

Consent for surgery. One of Iowa Health's system-wide initiatives was to rewrite the consent for surgery form. The director of risk management led the rewriting at the system level. After the form was reviewed by members of the affiliates' health literacy teams, risk managers, the law department, and attendants of the New Readers 2004 conference, it was pilot-tested at an affiliate hospital among one unit and a small group of clinicians. As the consent form is disseminated through the system, it is revised as needed and pilot-tested. Each affiliate chronicles its experience so that others can learn from the work.

The current form is simple, interactive, and easy for nursing staff to read if necessary. It requires nursing staff to ask patients what they understand their surgery will be. The patients' explanations are then written in the patients' words on the consent form. This method drives the use of "teach back" and allows nurses and physicians to review information that patients do not understand.

This effort has reinforced the idea that informed consent is a process, not a form. The health literacy teams sometimes hear from physicians and others that the form does not have enough information about risks and benefits. The team members use such opportunities to emphasize that the form only documents that a consent discussion took place—it does not replace the need for physicians to discuss the procedure's risks and benefits in ways that patients can understand.

Evaluate organizational performance over time. The Iowa Health affiliates understand that, unlike most quality improvement initiatives, health literacy does not have discrete beginning and end points. Also, health literacy does not only affect one specific patient population. The affiliates emphasize that having an impact on health literacy requires long-term commitment from the organization and team members. However, they have also found that, once communication projects begin, participants become energized by them because they require them to use creativity and strategic approaches.

To inform improvements to their communication and education efforts, Iowa Health System hospitals continually collect performance data and information on patient

needs. One affiliate, Iowa Health Des Moines, conducted a pilot project on patients' knowledge of Warfarin (Coumadin). Within one to eight weeks after receiving education from a pharmacist, 69 patients were surveyed on their knowledge about the medication and how it should be taken. Most (93%) patients responded correctly to at least one question and 35 percent responded correctly to all six. Patients answered "don't know" the most often to three questions: "Why do you need to take your Coumadin the same time each day" (29% didn't know); "What medicines should you NOT take while you are on Coumadin" (25% didn't know); and "What are some problems you might have when taking Coumadin that you should call your doctor about" (17% didn't know). The results of this survey will be used to help pharmacy educators improve how they provide information.

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San Francisco General Hospital

San Francisco General Hospital is a major arm of the San Francisco Department of Public Health. It is also affiliated with the University of California, San Francisco. These associations maintain the organization's focus on training, research, advocacy, and clinical care. San Francisco General has always served an international community of patients. This history, and the tradition of serving many waves of immigrants, has had a strong impact on the hospital's culture.

The mission of San Francisco General Hospital is to deliver humanist, cost-effective, and culturally competent health services to the residents of the city and county of San Francisco by providing access for all residents by: eliminating financial, linguistic, physical, and operation barriers; providing quality services that treat illness; promoting and sustaining wellness and preventing the spread of disease, injury, and disability; participating in and supporting training and research; and making a commitment to community involvement in health care needs.

Make leadership support visible. There is a strong, mission-driven culture at San Francisco General Hospital, evident at every level of the organization. Staff choose to be a

part of the organization. The explicit public service goals in the mission are widely known and followed. Leaders are willing to accept innovative ideas if they help patients.

Assess the needs of patients. Patient language data are coded at registration. If patients can provide information in English, they are often listed as English-speaking patients. If this needs to be adjusted later, anyone with administrative access can edit the data field. Registration staff ask all patients, “What is your primary language?” They also ask patients about their preferred language for written materials.

Needs assessments have been done in association with many of San Francisco General’s programs. The Cancer Awareness Resources and Education program did informal interviews with patients to gauge their levels of knowledge about cancer. The IDEALL project (Improving Diabetes Efforts across Language and Literacy) also assessed what types of information patients wanted to learn and practitioners wanted to convey.

Recruit and retain diverse staff. San Francisco General is committed to hiring a diverse workforce that reflects the patients being served. For example, the hospital has an eight-month training program for new immigrant nurses and has developed programs to help employees pursue educational opportunities by working and going to school part time while getting paid for working full time.

Some of the hospital’s positions have a designated language preference. The hospital has a waiver to hire only bilingual staff for these positions. For registration staff, the hospital has waivers for Spanish, Cantonese, and Russian. Bilingual staff members receive a small differential for using their language skills as part of their job for a certain number of hours each month.

Educate patients and use patients’ experiences. San Francisco General has developed innovative ways of using technology and group visits to improve communication and make it more patient-centered.

For example, the IDEALL project began as a way to address internal disparities in diabetes care.³⁸ The goal is to tailor interventions to patient language and cultural needs. Through an automated phone system, patients receive diabetes education and answer questions about their condition using their touch-tone keypads. Bilingual nurse care managers follow up with phone calls when patients’ responses are out of a designated range. The calls support self-management and promote behavior change. Patients are

asked to develop simple goals and action plans and are prompted to report if they achieve their weekly goals.

The IDEALL project's diabetes education and support groups take place one day a month for nine months. Patients develop simple action plans that focus on what is important to them and what they feel they can achieve. Many patients are low income, indigent, or homeless and have "burnt out" on diabetes care. During the support groups, health education discussions are integrated with clinical checks. Patients are taken aside and given individual testing or education, if required. The group visits take less time than individual visits and American Diabetes Association certification allows for them to be billed as if they were individual doctor visits.

Cancer Awareness Resources and Education (CARE). CARE groups provide cancer awareness, social support, resources, and education to low-income, indigent, or homeless people who cannot access other cancer programs that are offered throughout San Francisco. The program aims to improve cancer-related knowledge and provide support for patient's minds, bodies, and spirits. The program coordinates group activities, outings, meditation and relaxation activities, physician-led seminars, and other healing resources. Consideration is given to different learning styles and staff aim to build on patients' natural strengths and abilities. The program is available in English and Spanish and will soon be available in Cantonese.

Centering Pregnancy. This is a group-based prenatal care program that was developed in Connecticut and adopted by San Francisco General in 1999. Each group includes about 10 women who are due around the same time. The groups follow an agenda, but adapt to the participants' needs. Women discuss issues and share what they know about pregnancy and prenatal care from their own cultures. The visits provide all of the women's prenatal care. Individual patient issues and necessary exams are conducted privately while other group members talk with each other or engage in educational activities. The design and structure encourages empowerment. Women take their own vital signs and learn how to record their blood pressure levels in their charts.

Psychosocial Medicine. Body & Soul groups are one of many programs offered by San Francisco General's Psychosocial Medicine department. These spontaneous support and discussion groups are instigated by staff members in clinic waiting areas. A staff member shows up to a waiting room with a flip chart and begins a discussion among all the patients on a particular topic, such as what makes them angry. During the sometimes

chaotic discussions that ensue as patients come and go, staff try to validate patients' responses and reinforce the idea that patients can find solutions to their own problems.

Recognize the importance of culture and create a welcoming environment. San Francisco General's Immigrant and Refugee Clinic began after the Vietnam War, when Vietnamese refugees were coming to the city. Over time it has cared for waves of patients from other countries and regions, including Laos, Cambodia, Ethiopia, and Central America. The Immigrant and Refugee Clinic houses the Newcomers Health Program, a state-sponsored program to provide health care access to immigrants. The clinic has its own on-site, full-time, trained medical interpreters in the most prevalent languages. Interpreters also act as health workers and educators, performing outreach and case management.

Coordinate interpretation and translation services. San Francisco General is testing whether use of video medical interpretation (VMI) helps improve access to interpreters. Flat-screen monitors with attached video cameras are mounted on wheeled carts that can be moved between patient rooms. The units' cameras have wide-angle lenses that allow the interpreter to see the physicians and patients. The VMI addresses structural inefficiencies involved with interpreter travel and wait times. Interpreters now sit in one room and provide many interpretations during a single shift.

One challenge to implementing this system is to establish the interpreter pool. San Francisco General uses its own interpreters for most languages. Interpreters are located in an office about a block from the hospital. San Francisco General has recently begun sharing interpreters with two other California hospitals.

Be aware of low health literacy and use clear language. San Francisco General is testing Visual Medical Schedules (VMS) in the hospital's anti-coagulation clinic.³⁹ To help patients better understand their Warfarin (Coumadin) regimens, the VMS system uses a computer program to create a visual image of a weekly medication schedule. The schedule shows a picture of how much of their medication patients need to take each day. The program is available in English, Spanish, and Cantonese. Baseline testing found that, without the VMS, patients and physicians were only 50 percent concordant when asked about medication regimens. A recent random trial found that VMS works best for those patients who have poor blood test results and a different understanding of their schedule than their physicians or pharmacists. Other patients may have poor control, but not because they are unclear about their medication schedule.

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Sherman Hospital

Sherman Hospital is located in Elgin, Illinois, one of Chicago's northwest suburbs. In addition to being a regional heart center, Sherman Hospital is a Level II trauma center, and provides emergency services and , cancer care services, a diabetes center, orthopedic care, and a birthing center with a neonatal intensive care nursery. Sherman's mission is to serve the community's health care needs through a cost-effective continuum of preventive, diagnostic, therapeutic, and rehabilitative services in a manner that reflects a high level of quality and service. Sherman has provided its patients with trained interpreters since 1990 and a cross-cultural communication department has been in place since 2000. As of March 2006, on-site, trained interpreters are available 24 hours a day, seven days a week. Sherman serves a high proportion of Spanish speakers and a large Laotian population, both groups include many individuals with limited literacy and health literacy skills.

Make leadership support visible. Sherman Hospital has a committee on limited English proficiency to support improvements in patient-centered, cross-cultural communication. This committee includes multidisciplinary representatives from across the hospital. Members of this committee and other staff note that hospital managers need to set a high standard for patient-centered communication. For example, if a unit's managers always use interpreters, their staff will be more likely to do so.

Assess the needs of both patients and staff. Following guidance from the Office of Civil Rights, Sherman assesses all paths that a limited English speaker might take through the hospital. U.S. Census data are used to check what languages are spoken in the community and determine what percentage of patients in the immediate zip code report that they speak English "not at all" (and thus definitely need interpreter) or "less than very well" (and thus may need an interpreter).

Sherman's registration software has four fields that enable the hospital to capture patients' preferred language, whether they require an interpreter, their ethnicity, and race. A script has been created to train registrars and schedulers on how to ask race, ethnicity, and language questions, but it has not yet been implemented. Staff members are currently

being trained to ask patients, “What is your preferred language to communicate with staff?” If the language is not English, staff members are prompted by the software to fill in the “interpreter required” field. Staff members enter “yes” if patients cannot communicate well in English, even if they have English-speaking relatives or friends with them or if the staff members speak their language.

Software systems. Sherman notes that there is a disconnect between the information it should be collecting about patient race, ethnicity, and language according to national standards and the capabilities of available software. Staff members have also noticed discrepancies between federal and state requirements. Federal standards on Culturally and Linguistically Appropriate Services (CLAS) indicate that patients should be allowed to select multiple races or not select a race. In contrast, the state of Illinois requires statistics on race and will not accept blanks or “other.”

Train staff. One hour of the week-long orientation for all new staff includes an introduction to the cross-cultural communication department and interpreters. A second hour of orientation on cultural diversity is given by the chaplain. New physician orientation also includes a 10-minute introduction to the cross-cultural communication department and the interpreters.

Sherman’s interpreters seek to educate clinicians every time they interpret. Interpreters read a script outlining how to work with interpreters with all new patients and physicians. They may not read through the whole script with physicians they work with regularly, especially in emergency situations. If they have time, the interpreters try to talk to clinicians after the encounter to offer suggestions or reinforce positive behaviors.

Recognize the importance of culture. The hospital’s chaplains advocate respect for diversity in terms of culture, language, spirituality, gender, or other aspects of patients’ lives. The director of chaplaincy services sends e-mail notification of holidays from many cultures to staff. The director also attends department rounds and leadership meetings. Interpreters often refer patients to the chaplains if they perceive that they need to speak with someone.

Coordinate interpretation and translation services. Sherman staff noted several desirable characteristics in a manager of a cross-cultural communication department. Such a person should be assertive, passionate, and able to communicate with a diverse audience. He or she should have a background in interpretation and translation and a strong commitment to high standards and trained interpreters. The individual does not need a clinical

background, but does need clinical coaches. Finding the right person is often difficult. Sherman suggested that hospitals recruit staff from other organizations. For example, if another site has a successful interpreter services department, one of the trained staff might be interested in advancing in a leadership role at another hospital.

For languages other than Spanish, Sherman has recruited and trained community members to serve as on-call interpreters. For example, members of the Laotian community have assisted in interpreting and translating words and concepts from English into Laotian.

Sherman Hospital has a written policy that family members and friends should not be used as interpreters. Clinicians from the Emergency Department noted that this policy is sometimes difficult to follow for languages other than Spanish. Sherman has a waiver form that patients must sign if they do not want to use an interpreter. Interpreters are present for this discussion.

Translation services. At Sherman, documents that patients need to follow independently have the highest priority for translation. Some examples of such documents include marketing literature, billing information, discharge instructions, and special care nursery information. In some cases, translating a document into Spanish has alerted staff to information that is not clear in English. Most departments have been receptive to suggestions for changes to clarify documents in English and Spanish.

Sherman's procedural consent form has not been translated into Spanish because the hospital wants to ensure that interpreters are always present for consent discussions if a patient has limited English proficiency, or if a patient's family members has limited English proficiency and is involved in health care decision making with the patient. Sherman believes that if the form is in Spanish, interpreters might not always be called and patient safety could be an issue. All forms that patients sign include a space for interpreters to indicate that they were present for the encounter. This procedure was approved by the hospital's medical records committee.

Sherman purchased and adapted a terminology database (MultiTerm, the TRADOS Term Management Suite). This database serves as a common repository for translated words, phrases, and ideas; a tool for interpreters and translators to learn new terms in different dialects; and a method for ensuring information is translated consistently.

Assess and train interpreters. All interpreters must complete Bridging the Gap training and new interpreters are shadowed by experienced interpreters. Sherman interpreters must

also have a bachelor's degree and pass written tests when applying, after training, during a probationary period, and then periodically.

Sherman trains and tests interpreters on specific competencies, which reflect situations in which interpreters are most often used. The competencies identify “scripted encounters” where content is expected to be comprehensive and repeated. This includes pre-operative assessments, mother-baby teaching, and informed consent discussions.

Incorporate “teach back” into processes. Sherman is one of the National Quality Forum’s early adopter sites for the “teach back” method. Use of “teach back” began when staff in the Ambulatory Recovery Center (ARC) noticed that they were not clarifying information with English-speaking patients the way they were when they used interpreters with Spanish-speaking patients. All patients in the ARC are now asked to demonstrate understanding by explaining procedures in their own words.

Report and track communication problems. Sherman’s Integrated Safety Committee performs monthly rounds to ask staff members if they have what they need to provide safe health care. These rounds are done without managers present so that staff can speak freely. Feedback on interpretation often comes up. Sherman’s staff members are encouraged to report when interpreters are not available, since such information can be used to build the case for increased interpretation services.

Link communication performance to outcome indicators. Twice a year, cross-cultural communication encounters are included in a quarterly hospital performance report. The report is circulated to the Board of Directors, the hospital leadership team, and all unit managers and is presented at medical staff meetings. The Cross-Cultural Communication Department is in the process of developing performance indicators for communication. These indicators are not yet in use, but are intended to track safety events that relate to communication.

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University of Virginia Health System

The University of Virginia Medical Center (UVA) is an integrated network of primary and specialty care services. The hub of the Medical Center is a hospital with over 500 beds in operation and a state-designated Level I trauma center. The University of Virginia Health System's mission is to provide excellence and innovation in the care of patients, the training of health professionals, and the creation and sharing of health knowledge. The health system also includes the University of Virginia Schools of Medicine and Nursing, the Claude Moore Health Sciences Library, and the Health Services Foundation. The hospital serves large immigrant and refugee populations and large Hispanic populations.

Assess the needs of both patients and staff. UVA's computerized registration system (A2K3) has a field for special needs in which staff can indicate if a patient has communication needs. Once staff choose "yes," the system prompts them to specify need for a particular language and asks them to choose a language or fill out a field for languages not included in the list. Staff also specify patients' health literacy or other communication needs.

Forms used by UVA's Pre-anesthesia Evaluation and Testing Center have check boxes that allow practitioners to indicate if a patient has any communication needs. UVA's International Family Medicine Clinic maintains a database of all the patients that have been seen by its practitioners. This includes about 600 immigrants and refugees from 40 countries.

UVA assesses the communication needs of patient communities by looking at U.S. Census data and gathering current data from local school districts. Recently, UVA found out that the school districts surrounding UVA have students enrolled who speak 73 different languages.

Collect information on model programs. UVA staff works with the University HealthSystem Consortium to share best practices and learning across university health systems. For example, prior to making changes to UVA's informed consent forms, staff members collected forms used by other academic centers. Even with these samples, UVA struggled to balance the need to make the forms patient-centered and the need to include appropriate legal language.

Collaborate with community organizations. The International Rescue Committee began working in Charlottesville in 1998. UVA's International Family Medicine Clinic began in 2002. The International Family Medicine Clinic was developed to provide all immigrant and refugee patients with primary care physicians, make trained medical

interpreters available, keep families together, provide sufficient time for visits, coordinate scheduling, and track patients in the system.

UVA's International Family Medicine Clinic works closely with the International Rescue Committee and the local health department to coordinate the health care of refugees in Charlottesville. Without the International Rescue Committee as a community partner, caring for the diverse populations would require much greater hospital effort and resources such as social workers, case managers, and interpreters.

Partner on specific programs. The UVA library is actively involved in community education. As part of a train-the-trainer program, the library provided nurses with laptop computers and training to provide health education in rural communities. The library regularly trains community health educators.

Train staff. All non-physician staff members are required to complete annual, computer-based training that includes a diversity component and provides information on respecting patients and contacting interpreters. UVA recognizes the value in training all workforce members who may come into contact with patients on cross-cultural issues, including allied health professionals, housekeeping staff, and security staff.

Educate patients. The Virginia State Medical Board has made the informed consent process a state-wide standard that is part of licensing and grounds for disciplinary action. This applies to doctors, residents, chiropractors, occupational therapists, physician assistants, and others.

Consent for surgery. At UVA, the informed consent for surgery process has built-in redundancy. Patients are told that they will be asked multiple times to explain the procedure they are having to ensure their safety and understanding. Physicians first explain surgeries, including the risks and benefits. Patients are then asked to fill out the consent form, which indicates who will be doing the surgery, why they are having it, and the risks and benefits. During Pre-anesthesia Evaluation and Testing, patients are asked to explain the surgery they are having and are given information and instructions. The day before surgery, patients receive a call and are asked to explain their procedure and how they are preparing. On the day of surgery, nurse practitioners check consent forms to make sure they are signed. Finally, the circulating team asks patients to explain the procedures and read what is documented. If needed, the surgeon is called for clarification.

Consent forms. UVA's risk management department developed a standard template for informed consent forms. The template is written at the level of a junior in college, which UVA staff realize is a high standard. But, hospital leaders note, even forms written at the fifth-grade reading level are often not understood. They believe that the form should be a guide for a conversation about informed consent—not a stand-alone document. Some departments have two documents, one to lead the discussion and a second in simpler language that a patient can take home.

Patients do not get copies of informed consent forms, so UVA decided not to translate them. Instead, the forms have a line for interpreters to indicate when they are present for the discussion.

Intensive care unit informed consent. The intensive care unit recognized that common procedures were often done in time-sensitive situations with only implied consent. To address this, staff developed a consent form and process that could be presented to patients prior to the need for consent in an emergency. The ethics committee and risk management helped to decide what needed to be on the form. Risks, benefits, and other information are discussed with patients and family members. A notebook with further information is available in the waiting room.

Coordinate interpretation and translation services. UVA's language assistance office automatically receives a faxed document every time appointments are made in the computer scheduling system for patients who need interpreters. The faxed document lists the patient's name and code, appointment date and time, and language needed. The language assistance office arranges for an interpreter and puts an "L" in the system to indicate need for language services. Interpreter schedules are created on a daily basis, based on appointments. If a physician who speaks the patients' language sees the patient, staff indicate "P" in the system. If an interpreter cannot be arranged, they input "T" in the system to indicate "use telephonic interpretation."

On-site interpretation, telephonic interpretation, document translation, and other language assistance services are part of one cost center. This allows UVA to monitor and manage costs. For example, the use of telephonic interpretation increased significantly when the hospital began paying for the service, instead of making individual departments pay for it out of their budgets.

Assess and train interpreters. UVA has four on-site Spanish interpreters and one sign-language interpreter. All interpreters receive Bridging the Gap training. UVA also

contracts with interpreters employed by the International Rescue Committee for uncommon languages. These interpreters also complete Bridging the Gap training.

Incorporate “teach back” into processes. Use of the “teach back” method began at UVA in Pre-anesthesia Evaluation and Testing. It was implemented as a way to help reduce the number of same-day surgery cancellations. All surgery patients receive a phone call the afternoon before they come in. Staff members changed the way they conduct these calls. Instead of asking patients if they understand how to prepare for surgery, staff members now ask patients to explain how they are preparing for surgery. In less than a month the surgery cancellation rate was reduced from 8 percent to 0.8 percent.

UVA’s general medicine clinic conducted a few studies to document the level of health literacy among patients and determine residents’ perceptions of who is health literate. One-hundred patients were randomly selected to complete a health literacy assessment. Residents were also asked about their perceptions of patients’ health literacy levels. The study found that residents were wrong most of the time, both overestimating and underestimating health literacy levels.

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WakeMed Health and Hospitals

WakeMed Health and Hospitals is a private, nonprofit health care system based in Raleigh, North Carolina. It offers comprehensive medical care, specialized tertiary services, and emergency and trauma services to a multi-county region of central and eastern North Carolina. Delivering quality care to minority and underserved patients has been a focus and commitment of WakeMed since the hospital opened in 1961. Part of the mission of WakeMed is to provide quality health care to any citizen, regardless of place of origin or ability to pay. Wake County North Carolina has experienced rapid growth in its Hispanic populations, which increased 529.8 percent from the 1990 to 2000 Census. In response to the changing demographics of its patient populations, WakeMed recognized a need for formal language assistance services.

Collect information to demonstrate needs. Prior to developing its language assistance services, WakeMed used a planning grant from the Duke Endowment to collect data on its patients' communication needs. The hospital conducted a series of focus groups asking patients to relate their experiences with WakeMed. Staff members visited other North Carolina institutions, including a local health department, to see how language assistance services were being offered.

“Secret shopper” visits were conducted to determine patient experiences with different areas of the hospital and clinics. The hospital hired and trained three women, one Caucasian, one African American, and one Hispanic, to portray uninsured patients. These “shoppers” were each given an identical script and asked to visit the same five areas within the hospital. As a result of the visits, WakeMed changed several processes and assembled a cross-disciplinary planning team to improve the hospital's culture around cross-cultural communication.

Assess the needs of both patients and staff. When WakeMed created an interpretation and translation services department, its new manager spent her first two months assessing hospital needs. She met with managers of all the clinical areas and floors and observed how patients were registered and how they accessed the system. This evaluation considered what areas of the hospital had the highest volume of Spanish-speaking patients and thus the greatest need for interpreters and bilingual workforce members.

Collaborate with community organizations. WakeMed collaborates with ProFamilia to recruit Spanish-speaking individuals who are looking for jobs. ProFamilia is a community group that helps new immigrants study English, find jobs, and learn about banking, working, health care, and other aspects of life in the United States.

WakeMed also works with small, rural hospitals in North Carolina to provide guidance on developing language assistance services. WakeMed helps these hospitals assess bilingual staff members on their communication skills and review translated documents for accuracy.

Partner on specific programs. Wake Technical Community College, together with WakeMed, is developing an associate degree program for the hospital's current medical interpreters and anyone else who wants to become a medical interpreter. The program's courses will be offered online and at various campuses and a clinical rotation will take place at WakeMed's main hospital campus.

Recruit and retain diverse staff. WakeMed received a Community Health Improvement grant to train Spanish-speaking community members to work as patient account representatives. Two staff members were initially recruited and trained in Spanish and English. These individuals learned English in addition to the registration, insurance, and billing processes. This helped fill positions that needed to be bilingual and had high turnover rates.

Train staff. By encouraging all staff members to take language courses, WakeMed emphasizes the importance of communicating in languages that patients can understand. The hospital pays staff member's tuition for foreign language courses and has developed a language immersion program to help staff members refine their language skills. However, WakeMed has learned from experience that staff members will not become fluent in only a few weeks or even months. Through these classes, staff members come to recognize the high level of skill required to be a medical interpreter.

Workforce members need continual refreshers on the role of interpreters and how they should be used most effectively. As professional staff members become comfortable working with interpreters, they sometimes forget that an interpreter's primary role is to interpret and not to provide services. For example, after facilitating several conversations about informed consent or a particular medication regimen, interpreters have been asked to get informed consent or explain a medication regimen on their own while the physician or nurse leaves the room. When this happens, either the interpreter or the interpretation manager needs to remind the staff members about the interpreter's role.

Coordinate interpretation and translation services. WakeMed solidified its commitment to patient-centered communication by hiring a staff person whose primary role is developing and managing the interpretation and translation services department. This leader ensures that WakeMed is using its interpretation and translation resources effectively. According to WakeMed, effective managers of language assistance departments must have particular qualifications and qualities. They must be strong advocates for language assistance policies, capable of persuading leaders and staff that all patients deserve equal care, and able to provide rationale for new policies and procedures without becoming defensive or creating adversaries.

Assess and train interpreters and bilingual staff. The director of interpretation and translation services at WakeMed evaluates workforce members on their language skills and trains them to provide only the language assistance services they are qualified to provide. She developed the evaluations based on examples from the Massachusetts Medical

Interpreters Association and the National Council on Interpretation in Health Care. The assessments include written and oral tests of language skills, knowledge of medical terminology, interpreter skills, and translation skills.

Based on the results of their evaluations and job duties, staff members can qualify for one of three language skill levels:

- Level 1: Advanced skills. Qualified for medical interpretation and facilitation of informed consent discussions.
- Level 2: Intermediate skills. Qualified to provide services in a particular language, but cannot have informed consent discussions on their own.
- Level 3: Basic skills. Can welcome patients, make them comfortable, and provide directions.

Medical Staff Interpreters are full-time staff members whose primary responsibilities are interpretation and translation. These individuals are qualified for Level 1. All interpreters are trained to document, in the patient record, when they interpret and translate. Hospital forms also have a line for interpreters to sign when they have interpreted or done a translation.

Bilingual Providers are qualified to provide services (especially counseling and psychiatric) in English and another language. These individuals are typically qualified for Level 2. These individuals are not qualified to do medical interpretation and are required to call an interpreter if they ever feel unsure about an encounter. Volunteer Interpreters are all other staff members who qualify to use their language skills as part of their job. The duties they are allowed to perform depend on which of the three levels they achieve.

Incentive pay. To demonstrate the importance of language skills and effective communication, WakeMed's human resources and interpretation and translation services departments developed an incentive pay scale. Staff members who use their language skills for two or more hours per week as part of their job receive an incentive every pay period. Staff members at Level 1 receive \$120 each month, those at Level 2 receive \$80 each month, and those at Level 3 receive \$60 each month.

Staff members whose positions have a bilingual requirement receive their base salary plus 5 percent. This pay supplement began when some employees pointed out that they used their language skills for much more than two hours every week.

Providing pay incentives can create potential employee relations issues. It is therefore important for managers to explain the process clearly, before its implementation. When WakeMed implemented pay incentives, employees signed up to have their language skills assessed but did not realize that there would be a waiting period between sign-up, assessment, and increased pay. Managers must be prepared to provide feedback to native speakers who do not pass the assessment exam. They will need to explain their areas of weakness and the emphasis on knowledge of medical terminology.

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Woodhull Medical and Mental Health Center

Since 1982, Woodhull Medical and Mental Health Center has been the hospital hub of the North Brooklyn Health Network. It serves mostly residents of the geographical area known as North Brooklyn, New York. According to the 2000 Census, this area has a population over 507,000 residents, of which 26 percent are foreign-born. In 2001, Woodhull Medical and Mental Health Center began reengineering its organizational culture to focus on customer service and the patient's perspective. The goal of this process was to improve patients' access to appropriate care, help practitioners and other staff understand patient needs, and treat all patients with respect, regardless of their cultural or linguistic background.

Make leadership support visible. One of the drivers of Woodhull's customer service and language assistance programs was a change in organizational leadership. A new senior vice president joined the organization and brought with her several dedicated leaders as well as a commitment to meeting the needs of the patient community and the workforce.

Having committed leadership ensures that resources, both human and financial, are available for language assistance, training, and other related programs. Once a decision is made to allocate resources and programs are put in place, the cost considerations become a regular part of budget and planning activities.

Integrate communication initiatives. Woodhull deliberately embeds its new initiatives, including language assistance, customer service, and workforce training, into existing

departments and initiatives. This facilitates their introduction and ensures the efforts are integrated throughout the organization. For example, the patient relations department housed the organization's customer care coordinators, patient navigators, and interpreters. This department provides patients and staff with a one-stop resource when they have questions, need help, or want to provide feedback.

Train staff. As part of its focus on patients' language needs, the hospital developed a training protocol that oriented new workforce members to the communication policies and procedures and that introduced and reinforced the policies and procedures to existing staff.

All new employees participate in a four-day orientation that includes general information on the hospital's language assistance and communication programs. The training describes interpretation policies, telephonic interpretation systems, and the language bank. It also provides instructions on documentation of language assistance, cultural sensitivity, and pastoral care, including the impact of spiritual beliefs on health care.

Start with voluntary training. When new policies are put in place, Woodhull's leaders meet with staff and leaders in every department. In the case of language assistance, this means explaining the policies, introducing the interpreters and outlining their role, recruiting staff and support for the language bank, and promoting training courses.

Once the workforce becomes accustomed to new programs and training, Woodhull begins making them mandatory and tracking participation. For example, online training for continuing education units (CEU) or continuing medical education (CME) is available to professional staff. Two modules are available on general cultural competency and two modules are available on culturally competent clinical care. Woodhull began assigning these modules to departments and set dates for their completion.

Additional continuing education. As staff members became accustomed to frequent training, they began to attend mandatory sessions and even request additional training. Woodhull now conducts annual training needs assessment surveys to determine need for and interest in additional training.

Educate patients. At Woodhull, patient relations staff visit every new inpatient to provide information about patient rights and to identify any communication needs. Patient relations staff, including care coordinators and patient navigators, wear burgundy blazers to make them identifiable to patients.

Coordinate interpretation and translation services. With a large number of limited English proficient patients, Woodhull determined that language access was integral to provision of high-quality health care and assurance of patient safety. Woodhull formalized a three-tiered approach to language assistance and trained staff to access language assistance services in the following order: trained staff interpreters, Cyracom phones, and a language bank.

At Woodhull, all staff must document use of any language assistance in the patient's medical record. This includes using an interpreter, the Cyracom phones, or speaking to a patient in his/her own language. Interpreters also keep a log of all encounters. Patient refusal of an interpreter must be documented.

To access interpreters. Woodhull staff can call a general help line to access interpreters. This number is staffed through the patient relations department. All units have a sheet posted with interpreters' names, languages, and beeper numbers. In some cases, interpreters are assigned to particular clinics with significant need or scheduled to attend appointments with patients in need of interpretation.

Cyracom phone services. At Woodhull, Cyracom dual handset phones are the second line of language assistance. Woodhull staff members believe that all health care delivery sites should have access to phone interpretation, even if the sites do not have on-site interpreters.

Translated materials. The New York Health and Hospital Corporation provides all of the hospitals in its system with an intranet site for downloading forms and educational materials in multiple languages. Woodhull's nursing staff printed copies of these forms and educational materials for the top-10 conditions seen at the hospital in English, Spanish, and Polish.

Assess and train interpreters. Individuals who want to become interpreters must pass a 45-minute language assessment conducted by staff from Hunter College. Prospective interpreters must then complete 40 hours of basic training and additional advanced training (five weeks of theory and five weeks of practical learning). All training is conducted on-site at the hospital and teaches individuals to strictly adhere to the National Code of Ethics for Health Care Interpreters.

Assess and train bilingual staff. Language bank volunteers are required to pass a 45-minute assessment conducted by Hunter College staff. They also need to pass Hunter College's basic interpretation course, which is conducted at the hospital. The names of

trained language bank volunteers are included in a booklet that is circulated to all units and contains names, work hours, extension, language, and department. Staff members can call language bank volunteers directly or they can call the general help.

One challenge of using the language bank is that, while the volunteers often help in their own unit or in the hallways, they may not be able to leave their job when called to another unit.

Report and track communication problems. As Woodhull began to focus on customer service and patient needs, it also reviewed the grievance process. It began by examining the grievance structures at other hospitals.

In response to grievances, patient relations staff members either contact the patient to try to resolve the issue or ask the patient to put the complaint in writing for further investigation. Patient relations staff contact the department head and talk to the staff member who is the subject of the complaint. Patient relations staff also notify patients of the outcome or the expected time until an outcome is reached. All grievances are entered into a database. Monthly reports on complaints are sent to all department heads and a monthly summary report is sent to Woodhull's quality council. Grievance data are reviewed and used to identify any training needs.

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Appendix A. Examples of Ways Sites Demonstrate Promising Practices (part one)

Hospital	#1 Encourage Passionate Champions	#2 Collect Information	#3 Engage Communities	#4 Develop Workforce	#5 Involve Patients
Caritas Good Samaritan Medical Center Brockton, Massachusetts	Interpreters, outreach workers integrated on committees throughout hospital.	Interpreter encounters scheduled and tracked in interpretation department database.	Trained staff interpret at local physician offices. Interpreters trained as insurance counselors.	Communication training linked to quality and safety.	Interpreters visit limited English proficient inpatients twice a day, often with nurse.
Harborview Medical Center Seattle, Washington	Commitment, in mission, to vulnerable populations attracts passionate staff.	Language, race, and ethnicity entered into hospital-wide data system at registration.	“Community House Calls” uses navigator model to link hospital to community.	Incentive pay for language skills. Communication, interpretation competencies.	Respected physicians created legacy of engaging/respecting all patients.
Iowa Health System Des Moines, Iowa	System begins initiatives; senior leaders’ support enables affiliates to adopt them.	Small studies, online community data, and patient stories show needs.	Asks new readers and patients to critique documents, share stories, and advise.	Train with online health literacy module, “Help Your Patients Understand” video.	AskMe3 tool encourages patient questions. Informed consent forms simplified.
San Francisco General Hospital San Francisco, California	Leaders actively support innovation.	Patient language coded at registration. Interpretation dept. tracks encounters.	Immigrant and Refugee Clinic helps community navigate health system.	Incentive pay for language skills. Work-study opportunities for staff members.	Group visits, technology-based interventions help engage individuals.
Sherman Hospital Elgin, Illinois	Committee on limited English proficiency supports communication improvements.	Uses Census data on English proficiency.	Did community needs assessment with local United Way.	Cross-cultural communication staff train at orientations, in-services, meetings.	Staff trained to ask questions in ways that make sense to patients (e.g., weight in lb. or kg.).
University of Virginia Health System Charlottesville, Virginia	Staff members push improved communication at grassroots level.	Collects Census and school district data. Computer registration system tracks communication needs.	Intl. Fam. Med. Clinic, local Intl. Rescue Committee, health dept. link care for immigrants, refugees.	Mandatory, computer-based annual training includes respecting patients and interpretation.	Use of software that “talks” to patients in their language, until interpreters arrive.
WakeMed Health and Hospitals Raleigh, North Carolina	Annual staff evaluations include communication.	Focus groups and “secret shoppers” used to understand patient experiences.	Mentors rural hospitals in region. Works with local groups, community college.	Incentive pay for language skills. Mandatory training on communication.	Began accepting cash payments, hired bilingual financial staff to educate patients.
Woodhull Medical and Mental Health Center Brooklyn, New York	Leaders emphasize strong communication policies.	Grievance data, staff surveys used to identify training needs.	Community board receives updates and provides feedback.	Communication training at orientation; regularly reinforced.	Patient relations visit all inpatients to identify communication needs.

Appendix A. Examples of Ways Sites Demonstrate Promising Practices (part two)

Hospital	#6 Be Aware of Cultural Diversity	#7 Provide Effective Language Assistance	#8 Be Aware of Low Health Literacy	#9 Evaluate Performance
Caritas Good Samaritan Medical Center Brockton, Massachusetts	Outreach and interpretation staff serve as cultural brokers.	Trained, assessed interpreters available 24/7. Office in lobby.	Translated documents tested among patients.	Press Ganey surveys in top languages.
Harborview Medical Center Seattle, Washington	Team up to share cultural experience, meet patient needs. Developed Ethnomed Web site.	If high volume, interpreters should be employees (monitor quality, provide benefits). Some document translation, once English versions are clear and at appropriate reading level.	Information in audio formats.	Survey/interview interpreters to learn about communication gaps.
Iowa Health System Des Moines, Iowa	Increasing focus on cultural awareness, interpretation, translation.	Some document translation, once English versions are clear and at appropriate reading level.	System-wide efforts to introduce “teach back,” simplify forms/documents.	Track Press Ganey patient satisfaction scores. Evaluate use of AskMe3 tool.
San Francisco General Hospital San Francisco, California	Culturally appropriate care focus of Immigrant and Refugee Clinic, care/support groups.	Video Medical Interpretation used to improve access to interpreters on site and across partners.	Automated phone system to help monitor diabetes, Visual Medical Schedules to help patients understand Coumadin use.	All grant-funded projects include assessment on process and outcome measures.
Sherman Hospital Elgin, Illinois	Chaplains advocate respect for diversity, culture, language, spiritual preferences.	Trained, assessed interpreters available 24/7. Community members trained, on-call for rare languages.	National Quality Forum early adopter site for “teach back.”	Cross-cultural communication encounters included in hospital performance reports.
University of Virginia Health System Charlottesville, Virginia	Intl. Fam. Med. Clinic centers care around families. Staff, leadership committees on cultural issues.	Requests for interpreters automatically faxed to coordinator when appointments are made.	Use of “teach back” has reduced surgery delays/cancellations	Track patient follow-up with Intl. Fam. Med. Clinic. Track when interpreters requested, whether they are provided.
WakeMed Health and Hospitals Raleigh, North Carolina	Cultural awareness/sensitivity woven into employee training.	Bilingual staff and interpreters trained, qualify for levels of language skill.	Adjust processes to help patients unfamiliar with accessing health care system (e.g. accepting cash payment for services).	Communication on annual employee evaluation. Track interpreter use, patient/staff survey results, complaints.
Woodhull Medical and Mental Health Center Brooklyn, New York	Art from local artist and flags from patients/staff home countries create welcoming environment.	Trained, assessed interpreters. Trained, assessed bilingual staff language bank.	Training staff to communicate in clear, non-technical language.	Track interpreter use, patient/staff survey results, grievances.

APPENDIX B. PROJECT METHODOLOGY

With funding from The Commonwealth Fund, the Ethical Force Program, and the Health Research and Educational Trust, we conducted eight site visits to determine how hospitals use patient-centered communication to improve health care for vulnerable patient populations. Patient populations can be vulnerable for many reasons. For the purposes of this project, patient populations are considered vulnerable if they have an increased likelihood of experiencing gaps in communication during interactions with the health care system. This includes patient populations whose members have limited or no English proficiency, a culture that is not well understood by personnel in the organization, and/or limited health literacy skills.

In early 2005, the Institute for Ethics at the American Medical Association and the Health Research and Educational Trust solicited nominations of hospitals that had demonstrated a commitment to patient-centered communication with vulnerable patient populations. A call was distributed to the Ethical Force Program's Oversight Body and Expert Advisory Panel and it was posted on the American Medical Association and American Hospital Association Web sites. It was also e-mailed to several listservs, including those of the American Medical Association, American Hospital Association, American Academy on Physician and Patient, National Council of Interpretation in Health Care, and CLAS-TALK.

Almost 80 hospitals were nominated and invited to submit applications for recognition and participation in this project. Of the 38 hospitals that submitted complete applications, eight were selected by the Ethical Force Program's expert advisory panel. Site selection balanced the need to choose a range of hospital sizes and types with a range of populations served and focus areas. The expert panel also selected hospitals that had programs at various stages of development. Because one goal of the project was to identify practices that could be adopted by any hospital across the country, panelists avoided selecting only large, academic hospitals that had mature, successful programs for patient-centered communication. Instead, hospitals were chosen because they had developed innovative strategies that had the potential to improve communication whether they were adopted by a large, academic site or a small, rural facility.

Staff members from the American Medical Association and the Health Research and Educational Trust conducted two-day site visits at each of the eight selected sites. The site visits included a tour of the hospitals, interviews with hospital executives, and focus

group discussions with physician and non-physician clinical staff, managers and staff of highlighted communication initiatives, frontline staff, and patients.

The interviews and focus groups addressed three main topics:

1. organizational factors that led them to develop initiatives to improve patient-centered communication;
2. what they thought every U.S. hospital or health system should be doing to improve patient-centered communication; and
3. lessons learned from their efforts.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

[*Health Care Disconnect: Gaps in Coverage and Care for Minority Adults*](#) (July 2006). Michelle M. Doty and Alyssa L. Holmgren, The Commonwealth Fund. In this issue brief, the authors report that Hispanic and African American working-age adults face gaps in health insurance coverage, problems accessing care, and medical debt at higher rates than their white counterparts.

[*The Changing Face of Race: Risk Factors for Neonatal Hyperbilirubinemia*](#) (May 2006). Anne C. Beal, Shu-Chiung Chou, and R. Heather Palmer. The authors of this article found significant disparities between the race assigned to mothers of newborns by hospital staff and mothers' self-described race, potentially undermining efforts to identify and treat hyperbilirubinemia—an acute and potentially devastating form of neonatal jaundice.

[*Complementary and Alternative Medical Therapy Use Among Chinese and Vietnamese Americans: Prevalence, Associated Factors, and Effects of Patient–Clinician Communication*](#) (Apr. 2006). Andrew C. Ahn, Quyen Ngo-Metzger, Anna T. R. Legedza et al. *American Journal of Public Health*, vol. 96, no. 4 (*In the Literature* summary). While roughly two-thirds of Asian American study respondents reported using some form of complementary or alternative therapy, fewer than one of 10 discussed this treatment with their doctor, according to the authors of this article.

[*A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity*](#) (Mar. 2006). David W. Baker, Kenzie A. Cameron, Joseph Feinglass et al. *American Journal of Public Health*, vol. 96, no. 3 (*In the Literature* summary). The authors of this article report that allowing patients to describe their racial or ethnic background in their own words may improve the accuracy of such data.

[*Journal of Health Politics, Policy and Law*](#) (Feb. 2006) (*In the Literature* summary). In this special issue of the *Journal* (vol. 31, no. 1), four articles supported by The Commonwealth Fund attempt to refocus policy discussion on finding solutions to the problem of disparities in health care, including efforts now under way at the state and local levels.

[*The Impact of Interpreters on Parents' Experiences with Ambulatory Care for Their Children*](#) (Feb. 2006). Leo S. Morales, Marc Elliott, Robert Weech-Maldonado, and Ron D. Hays. *Medical Care Research and Review*, vol. 63, no. 1 (*In the Literature* summary). Having access to medical interpreters can not only substantially reduce racial and ethnic disparities but also improve patients' experiences, say the authors of this article.

[*Navigating the Terrain Between Research and Practice: A Collaborative Research Network \(CRN\) Case Study in Diabetes Research*](#) (Jan./Feb. 2006). Margaret A. Handley, Hali Hammer, and Dean Schillinger. *Journal of the American Board of Family Medicine*, vol. 19, no. 1 (*In the Literature* summary). The authors of this article say that researchers designing practical clinical trials must strive to balance a study's internal validity with its external validity, while making clear how their decisions may influence the interpretation of results.

