The Curriculum Vita
of
Sheila M. Kelty

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HEALTHCARE ADVISOR

Proactive, patient focused healthcare executive with a 25-year record of accomplishment in leadership, finance, and business administration. Engaged in diplomatic, culturally sensitive, and cooperative relationships with professionals and non-professionals at all levels and viewed as a passionate leader with excellent team-building skills. Demonstrated history of using analytical thinking and deductive reasoning skills to solve problems at the root-cause, and to anticipate problems and proactively create effective solutions. Motivational, team-oriented leader committed to employee development and continuing education. Community-minded citizen who exemplifies the image of the hospital within the community while maintaining an active role in civic organizations.

AREAS OF EXPERTISE

- Operation management
- Financial Management
- Project Management
- Operating and Capital Budget Development
- Cross-Functional Team Collaborations
- Quality Improvement

PROFESSIONAL EXPERIENCE

Purdue University; West Lafayette, IN **4/10 - Present**
Healthcare Advisor (September 2012 – Present)
Hospital Administrator (April 2010 – August 2012)

Purdue University is known for science, technology, and agriculture. The Veterinary Teaching Hospital's annual net revenue is $10 million. The multi-specialty hospital clinical operations consist of Emergency Critical Care, Internal Medicine, Orthopedics, Ophthalmology, General Surgery, Radiation Oncology, Dentistry and Oral Surgery, Neurology, Oncology, Allergy, Dermatology, Nuclear Medicine, and Internal Medicine.
The Clinical Support Services operations consist of Emergency Medical Services, Rehabilitation Services; Electronic Medical Record, Radiology.
Purdue Healthcare Advisors is a not-for-profit entity created in 2005 by a partnership among Purdue's Technical Assistance Program, the Regenstrief Center for Healthcare Engineering, and the Indiana Hospital Association. Its mission is to improve healthcare quality, safety, and efficiency by applying the principles of engineering, management, and science.
The original vision to help hospitals with short-term quality improvement projects expanded to incorporate long-term consulting, coaching, and/or training services involving hospitals and health systems, physicians and healthcare professionals and workers in all capacities, public health departments, public and private healthcare associations/agencies, and healthcare vendors/suppliers.

As the healthcare industry in Indiana begins to dramatically change the way it does business, Purdue Healthcare Advisors brings expertise on the latest strategies and competencies to improve care, manage margins, and facilitate compliance.

Key Achievements:

Healthcare Advisors:

- Perform economic simulation models for hospital and healthcare projects.
- Oversee Purdue Healthcare Advisors Academy - public workshop/course offerings.
- Calculate pricing for fee-for-service advising engagements.
- Write technical papers in collaboration with colleagues.
- Write grant requests in collaboration with colleagues.

Veterinary Teaching Hospital:

- Managed the implementation of a walk-in emergency clinic that increased caseload by 25%.
- Revised policies, trained staff, and implemented standardized processes for payment at time of services, which resulted in a 30% decreased in total Accounts Receivable within 6-months.
- Overall management and direction of the hospital.
- Oversee day-to-day operations of the veterinary teaching hospital to ensure high quality of care, sound fiscal operation, regulatory compliance, and accreditation.
- Provide oversight and direction for Budgeting, Patient Accounts, and Financial Management.
- Collaborate with the Dean, clinical faculty, and University leadership to develop and implement the hospital strategic plan in accordance with the clinical, educational, and research missions of the School and University while facilitating growth through new and existing service lines.
- Lead the management team and medical leadership of the hospital to reduce costs, enhance revenues, increase client satisfaction, and achieve utilization and quality goals.
- Coordinate development and administration of hospital policy.
- Oversee Medical Staff and Hospital Personnel to create optimal working relationships.
- Collaborate with Development Office for public relations and communications matters to attract partnerships with the community, vendors, and other stakeholders.
- Respond to the needs of Medical Staff, employees, and clients.

Community Hospital of Bremen; Bremen, IN **01/05 - 07/09**
Vice President
CHB is a not-for-profit, 24-bed acute care critical-access-hospital with 130 FTEs and $17 million annual net revenue. CHB completed a 65,000 sq. ft. replacement hospital in 2006.

Key Achievements:

- Serve as Equipment planner for the replacement hospital facility-building project with equipment budget of $3 million and building budget of $19 million.
- Establish affiliation relationship with a regional medical center for purchasing, laundry, and bio-medical engineering.

- Negotiate contracts with GPOs and Vendors to decrease orthopedic implant and supply expenses by 30% and overall medical-surgical supply expenses by 10%.
- Develop and implement a branding/marketing plan for the hospital including television and billboard advertising, local sponsorships, and web site development.
- Implemented room-service style dining for in-patients.
- Advise the Planning & Finance committees of the Board of Directors regarding Balanced Scorecard, capital assets, and planning information.
- Chair of Indiana Statewide Rural Health Network (InSRHN) Materials Management Roundtable - Indiana Rural Health Association.
- Chair of the Hospital Stewardship and Environment of Care Committees. Member of Hospital Senior Leadership Team, Compliance, Infection Control, Product Standards, and Surgery Committees.

Memorial Hospital, South Bend, IN **06/01-06/03**
Project Manager/Applications Analyst
A not-for-profit, 350-bed acute care regional teaching hospital with a residency program and a Level II trauma center. Memorial employs 3,800 people.

- Manage the 18-month implementation of PeopleSoft MRP system for Finance & Materials Management. Project scope: General Ledger, A/P, Purchasing, Receiving, Inventory, and Distribution.
- Track personnel, tasks, and assignments on the implementation using Microsoft Project.
- Train end-users on the software for their departments.
- Demonstrate functional knowledge of software and hardware, organizational skills, efficiency, leadership, and the ability to keep personnel on time and on budget for a successful implementation.
- Serve as liaison between Information Systems personnel and end-users in finance, materials management, foundation, health & lifestyles center and nutritional services.
- Meet with computer users in these departments to review department software needs.
- Perform trouble shooting when software was not working as expected.
- Demonstrate functional knowledge and use of Microsoft Office, Microsoft Project, Internet, Intranet, PeopleSoft, and McKesson software.

Digger Specialties, Bremen, IN **06/99 – 05/01**
Purchasing Manager
Manufacturing company producing vinyl fencing, decking, & railing with annual sales of $12 million.

- Manage purchasing, inventory and receiving personnel in a manufacturing facility, which produced aluminum and vinyl fencing and decking products.
- Implement an import contract with a raw materials supplier in China. Determine orders based on volume and weight capacity of the shipping container. Place orders based on product lag time due to transportation and import delays. Research import regulations and paperwork needs.
- Compile supply chain financial data.

- Formulate inventory plans to support company sales objectives for multiple product lines. Assist with annual budget and strategic planning. Manage and prepare monthly/annual reporting. Monitor compliance to established goals.
- Monitor vendor reliability - accuracy of order, timeliness of delivery, and product quality.
- Negotiate with vendors for products, pricing, availability, and delivery schedules.
- Select products and materials for purchase. Prepare bid requests, review bid proposals, and prepare purchase orders. Maintain all records of purchases, usage, and inventory.
- Direct all activities related to raw material procurement and storage. Maximize order fill rates with minimum investment in raw materials.
- Coordinate special projects as needed, including the implementation of a new software system for the purchasing and inventory departments.

EDUCATION, LICENSURE, TRAINING & AFFILIATIONS

Ball State University; Muncie, IN 1994
Master of Business Administration

Ball State University; Muncie, IN 1988
Bachelor of Science, Corporate Finance, Financial Institutions

American College of Healthcare Executives, 2008
Board Certified Fellow

RESEARCH AND PUBLICATIONS

Doctoral Dissertation (in progress): Culturally and linguistically appropriate services in critical access hospitals.

COMMUNITY ACTIVITY

Kiwanis Club 2005-2009; 2013

United Way of Marshall County - Bremen Cabinet 2007-2008

Heart & Hands (not-for-profit service organization) - Board Member 2008

Bremen Public Schools, Board Member 2013

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN CRITICAL ACCESS HOSPITALS

Sheila M. Kelty

A journal article submitted in partial fulfillment of
the requirements for the degree of
Doctor of Health Administration

School of Health Sciences

Central Michigan University
Mount Pleasant, Michigan
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This dissertation is dedicated to my loving husband, David, and my beautiful, brilliant children, Sean and Olivia, for their steadfast support, enduring patience, and constant encouragement throughout the course of my doctoral program. It is also dedicated to my parents, Stephen *& Jolene Capes who always encouraged me to learn, inspired me with their will to never give up and always believed in me more than I believed in myself. I love you all.
*Deceased

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I would like to thank all the faculty members in the Doctor of Health Administration program for your expertise in teaching all the courses in this program. Without the background courses, this dissertation would never have come to fruition.

I would also like to thank Brock Slabach, Senior Vice President for member services at National Rural Health Association for paving the way for me to advertise my survey in the NHRA Today e-newsletter.

ABSTRACT

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES
IN CRITICAL ACCESS HOSPITALS

by Sheila M. Kelty

The United States Supreme Court has interpreted Title VI of the Civil Rights Act of 1964 to mean that all healthcare providers that accept Medicare and Medicaid must provide culturally and linguistically appropriate services (CLAS) for their patients (Youdelman, 2008). In 2001, the United States Department of Health and Human Services' Office of Minority Health issued a set of national standards for CLAS. Many large, urban hospitals now use on-site professional language-concordant providers and other diverse staff members with expertise in ethnic, racial, and religious matters. This study examines provisions of CLAS in rural areas. Critical Access Hospitals (CAHs) that are in geographic locations that do not have long histories of culturally diverse populations or limited-English proficiency populations may not have policies and procedures in place to offer CLAS. These CAHs may not be collecting cultural or language data from their patients. They may not be training their staff on the cultural needs of patients concerning dietary needs, religious beliefs, cultural traditions, and health literacy. There may be limited human resources initiatives concerning cultural and linguistic activities such as recruitment and retention of clinical and non-clinical employees who mirror the culture and language of the diverse patient population. In 2007, the Joint Commission performed a study of CLAS in sixty hospitals however; only ten small hospitals (26-99 beds) were examined in detail.

This descriptive, survey-based study extends earlier research by exploring how CAHs across the nation provide CLAS for their patients. Personal emails announcing the study and providing the survey link were sent to officers of 968 of the 1,329 CAHs in the United States

(73%). An online survey was completed by 137 of the 1,329 CAHs in the United States (14.15% participation rate, 10.3% of all CAHs). Participating CAHs reported that 91.04% of their patients spoke English (median = 97.00%, SD =14.11, range = 0-100%). They also reported employing few employees with CLAS specific duties (median = .05 FTE, SD = 3.52, range = 0 - 26.25). CAHs with larger non-White and non-English speaking populations had a greater variety and more frequent use of language services than CAHs that served smaller non-White and non-English speaking populations. Only 7.40% of the CAHs in this study reported that they always used trained interpreters when encountering Limited English Proficiency patients. Moreover, 50.95% of the CAHs in this study reported that they never used trained interpreters. CAHs that collected cultural and linguistic information from patients were significantly more likely to have mechanisms in place to ensure this information followed the patient throughout the continuum of care than CAHs that did not collect such information, $r = .33$, $p < .001$. These CAHs also offered significantly more mechanisms to address their patients' cultural and linguistic needs, $r = .41$, $p < .001$. CAHs with larger non-White populations were significantly more likely to employ FTEs directly related to CLAS than CAHs that served smaller non-White populations, $r = .22$, $p = .009$. The same finding applied to CAHs with larger non-English speaking populations ($r = 17$, $p = .03$). Finally, there were no significant associations between CAHs serving larger non-White populations and non-English speaking populations and provision of CLAS-related training to CAHs employees. These results could be used by CAH executives to evaluate their hospitals' CLAS information collection, mechanisms for meeting CLAS needs, their employees' CLAS competencies, and CLAS training needs.

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KEY TO ACRONYMS

CAH Critical Access Hospital

CLAS Culturally and Linguistically Appropriate Services

ED Emergency Department

HLC Hospitals, Language, and Culture: A Snapshot of the Nation (report)

LEP Limited English Proficiency

OPI Over-the-Phone Interpreting

VRI Video Remote Interpreting

DEFINITION OF TERMS

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) - The National Standards set forth by the United States Department of Health and Human Services Office of Minority Health as published in December 2000.

Culture - "The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (United States Department of Health and Human Services Office of Minority Health, 2001) .

Cultural competence - "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (United States Department of Health and Human Services Office of Minority Health, 2001).

Linguistic competence - "Providing readily available, culturally appropriate oral and written language services to patients with limited English proficiency (LEP) through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators" (The Joint Commission, 2007).

Culturally and linguistically appropriate care - "Health care services that are respectful of and responsive to cultural and linguistic needs" (United States Department of Health and Human Services Office of Minority Health, 2001).

Competence - "Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (United States Department of Health and Human Services Office of Minority Health, 2001).

Disparity - "Racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention" (Smedley, Stith, & Nelson, 2003).

Health Literacy - Health literacy is the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions (Centers for Disease Control and Prevention, 2011).

Language services - "Mechanisms used to facilitate communication with individuals who do not speak English. These services can include in-person interpretation using a qualified interpreter, bilingual staff, or the use of remote interpreting systems such as telephone or video interpreting. Language services also refer to processes in place to provide translation of written materials or signage" (The Joint Commission, 2007)

Limited English Proficiency - "Persons who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English" (United States Department of Justice Civil Rights Division).

Interpreter - "a person who renders a message spoken or signed in one language into a second language, and who abides by a code of professional ethics" (The National Council on Interpreting in Health Care, 2008).

Hospital employed interpreter - "An individual who is employed by the hospital for the sole purpose of language interpreting. For purposes of this study, we excluded contract interpreters from this definition" (The Joint Commission, 2007).

Contract interpreter - "An individual, either freelance or employed by an interpretation agency, who is contracted by the hospital to provide interpreter services. These individuals may be full or part-time" (The Joint Commission, 2007).

Bilingual staff/employee - "An employee who is a proficient speaker of two languages and may provide direct services in both language, but without additional training is not qualified to serve as an interpreter" (The National Council on Interpreting in Health Care, 2008).

Qualified interpreter - "An individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care" (The National Council on Interpreting in Health Care, 2008).

Ad hoc interpreter - "An untrained person who is called upon to interpret, such as a family member interpreting for her parents, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual in a hospital waiting-room who volunteers to interpret" (The National Council on Interpreting in Health Care, 2008).

Over-the-phone interpreting - "Interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through a speaker-phone or headsets. In health care settings, the principal parties, e.g., doctor and patient, are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone" (The National Council on Interpreting in Health Care, 2008).

Video remote interpreter - "An interpreter in a remote location to both see and hear the parties for whom he/she is interpreting via a TV monitor. The interpretation is relayed to the principal parties by speakerphone or through headsets. Two-way interactive television can also be used, so that the other parties can interact with the interpreter as if face-to-face" (The National Council on Interpreting in Health Care, 2008).

Translator - "A person who translates written texts, especially one who does so professionally" (The National Council on Interpreting in Health Care, 2008).

Trained Healthcare Interpreter - An interpreter who knows medical terminology in both languages and has training and experience in healthcare ethics.

MANUSCRIPT

ABSTRACT

Purpose

This descriptive, survey-based study extends earlier research by exploring how Critical Access Hospitals (CAHs) across the nation provide Culturally and Linguistically Appropriate Services (CLAS) for their patients.

Methods

A national electronic survey of CAHs in 45 states. Personal emails announcing the study and survey link were sent to 968 of the 1,329 CAHs in the United States (73%). The survey was completed by 137 of the 1,329 CAHs (14.15% participation rate, 10.3% of all CAHs).

Results

CAHs with larger non-White or non-English speaking patient populations had a greater variety and more frequent use of language services than CAHs that served less diverse populations. CAHs that collected cultural and linguistic information from patients were significantly more likely to have mechanisms in place to ensure this information followed the patient throughout the continuum of care. CAHs that collected cultural and linguistic information from patients offered significantly more mechanisms to address the patient's cultural and linguistic needs. CAHs with larger non-White or non-English speaking populations were significantly more likely to employ FTEs related to CLAS than CAHs that served less diverse

populations. CAHs with larger non-White or non-English speaking populations were not significantly more likely to provide CLAS training than CAHs that served less diverse populations.

Conclusions

Collection of patient demographic information may relate to use of that information in the patient's healthcare encounter. Location in a diverse population may not be an indicator of the CAHs provision of CLAS services.

Key Words

Critical Access Hospitals, Culturally and Linguistically Appropriate Services.

INTRODUCTION

Rural critical access hospitals (CAHs) struggle with how to provide culturally and linguistically appropriate services (CLAS) while at the same time keeping expenses low. This is a growing concern because of the increase in diverse populations in rural areas. The purpose of this study is to determine if CAHs have policies and procedures in place for CLAS services, whether they are collecting cultural and linguistic data at admission, and how they are using the data to improve services for culturally diverse and limited English proficiency (LEP) patients.

Language interpretation services in health care are important because (a) immigrants have a higher rate of infectious diseases than the established United States population, (b) continued travel between the native country and the United States creates a higher risk of exotic disease transmission, and (c) physicians tend to order more diagnostic tests when they cannot understand the patient (Armanda & Hubbard, 2010). The potential for misunderstanding carries a burden for both the provider and the patient in terms of finances and patient satisfaction.

There is reason to believe that Latino LEPs do not receive the same follow-up care as others after an initial physician visit. For instance, a study at UCLA reported that significantly more LEP Latinos than language concordant patients are discharged from the Emergency Department (ED) without a follow-up appointment (Sarver & Baker, 2000). However, compliance in attending the follow-up appointment did not differ between the study groups overall or when broken down by demographic characteristics, thus adding to the belief that LEP patients should use trained interpreters if language concordant providers are not available.

Additionally, hospitals see decreased patient compliance and lower patient satisfaction when they do not offer language services (Whitman & Davis, 2008). Compared to patients with no language barrier, patients who do not speak the language of the provider receive additional

diagnostic testing and have a longer length of stay (Hampers, Cha, Gutglass, Binns, & Krug, 1999). Using a professional trained interpreter results in less diagnostic testing, lower cost, and shorter length of stay. Therefore, a reduction in over utilization of diagnostic testing, higher medical costs, and longer lengths of stay might occur if all hospitals offered timely, professional language interpretation services for LEP patients.

The law requires that health care providers offer appropriate language services to their patients. However, a low percentage of LEP patients utilize professional interpretation services in EDs of small, rural hospitals. This could be because historically, LEP immigrants settled in large cities, therefore, rural providers did not need to be concerned with providing appropriate language services. LEP patients rely more on emergency care than primary or preventative care (Youdelman, 2008) which is an important fact, since the Hispanic population is growing at a fast rate in rural areas and rural hospital EDs are not well equipped to provide services in Spanish.

In the absence of a language concordant provider, there are multiple options available for interpreter services in healthcare. In order to provide proper quality services the hospital must identify the cultural and language needs of the individual patient. There has been little published research on these topics. One study identified that LEP patients were deemed likely to benefit from language assistance based on the responses to a question regarding how well the patient spoke English and one asking what language the patient preferred to receive his/her medical care (Karliner, Napoles-Springer, Schillinger, Bibbins-Domingo, & Perez-Stable, 2008). Such measures help hospitals identify those patients who truly need language services. In reviewing attitudes and practices of hospital staff regarding the use of trained interpreters it was determined that only nine percent of hospital clinical staff had training in how to work with an interpreter and that clinical staff members were not encouraged to use interpreters within their clinical

department (Hudelson & Vilpert, 2009). Citing lack of time and inconvenience, resident physicians tend to use their own limited foreign language skills to get by even when trained interpreters are available (Diamond, Schenker, Curry, Bradley, & Fernandez, 2009). These findings should be unsettling to hospitals who wish to satisfy Title VI of the Civil Rights Act of 1964 concerning providing language services for LEP patients.

Language is such a large topic that sometimes hospitals neglect the cultural portion of CLAS. In order to become a hospital that routinely provides CLAS, there must be an established and consistent method for collecting data regarding the race, ethnicity, and language of the patients. These variables affect health outcomes, therefore, in order to provide the best outcomes, it is important that the healthcare provider looks at how the patient identifies himself/herself (Graves, Like, Kelly, & Hohensee, 2007). Hospital employees should be trained on the health disparities affecting the cultures of their patient base as well as the cultural health beliefs of these various cultures. This training also increases awareness of cultural and linguistic issues that could affect outcomes (Graves, et al., 2007). It is important that all hospital employees, not only clinical staff are included in the CLAS initiatives. It is usually the registration personnel that collect the cultural and language data and they must ensure that this information is passed along with the patient throughout the patient encounter. Therefore, the registration personnel must understand the necessity of the CLAS initiatives and realize their stake in the cycle of care for the patient.

The most comprehensive study to-date regarding CLAS was performed in 2007 and is entitled Hospitals, Language and Culture: A Snapshot of the Nation; it is referred to as HLC (The Joint Commission, 2007). HLC collected qualitative and quantitative data to determine the challenges associated with providing CLAS, how hospitals address the challenges, and if there

was anything that could be shared with other facilities. Most of the hospitals in the HLC study were larger, urban hospitals. There has not been a comprehensive study of CAHs related to CLAS. Therefore, in order to determine how well CAHs are providing CLAS for their patients, this study used a modified version of the HLC survey to collect quantitative data from CAHs across the United States.

Statement of the Problem

CLAS is a costly investment for hospitals. Many rural hospitals do not have the financial ability to invest large sums into CLAS for their diverse patient populations. Hospital administrators must be able to determine what cultures and languages are present in their patient base. Once that data is known, administrators must determine how to provide appropriate services for these patients. This will allow them to create policies and procedures regarding CLAS. It will also allow them to determine what type of recruitment and retention efforts need to be undertaken to employ staff members who mirror the culture and language of the community or patient population. In order to determine the best use of the hospital's budget the hospital must be able to properly identify which patients require CLAS and encourage hospital staff to follow hospital policy as it relates to culture and language. Specifically, this study is important in independent, CAHs, which are not affiliated with larger systems that might share in the financial burden of providing language services to the patients. These hospitals must find a way to provide effective language interpretation services and cultural awareness programs that are cost effective. Accreditation and federal funding for these facilities could be limited if these hospitals do not to meet the requirements. This study addresses the question of how CAHs provide cultural and linguistic care for their diverse patients.

Research Questions

A study of the CLAS regulations and knowledge of several CAHs lead the researcher to formulate questions about CAHs and the use of CLAS standards. These questions fall into five categories: 1) Collection of information and mechanisms to meet CLAS, 2) Collection of information and CLAS in continuum of care, 3) Ethnic/linguistic ratios and human resources, and 4) Linguistic ratios and use of language services.

Specific questions for each category include:

1) Collection of information and mechanisms to meet CLAS

Is the collection of cultural and linguistic information from patients upon admission associated with the presence of mechanisms to meet these cultural and linguistic needs?

2) Collection of information and CLAS in continuum of care

Is the collection of cultural and linguistic information from patients upon admission associated with the presence of mechanisms to ensure this information follows the patient throughout the continuum of care?

3) Ethnic/linguistic ratios and human resources

3a) Do CAHs that have larger non-white populations have a greater number of employees with CLAS specific duties than CAHs that have smaller non-white populations?

3b) Do CAHs that have larger non-English speaking populations have a greater number of employees with CLAS specific duties than CAHs that have smaller non-English speaking populations?

3c) Do CAHs that have larger non-white populations provide more CLAS specific training than CAHs that have smaller non-white populations?

3d) Do CAHs that have larger non-English speaking populations provide more CLAS specific training than CAHs that have smaller non-English speaking populations?

4) Linguistic ratios and use of language services

4a) Do CAHs that have larger non-English speaking populations have a greater variety of language services available and use them more often than CAHs that have smaller non-English speaking populations?

4b) Do CAHs that have larger non-White populations have a greater variety of language services available and use them more often than CAHs that have smaller non-White populations?

Significance of the Study

The study is of great importance to the rural, critical-access-hospitals that have seen an influx of diverse populations into rural areas. This study is significant because it helps CAHs determine how well they are providing CLAS to their diverse patient base. This knowledge will allow CAHs to become a factor in reducing health disparities.

METHODS

Description of the Sample

The population for this study included the 1,329 CAHs in the United States located in forty-five states. To qualify as a CAH a facility must meet specific criteria established by the Centers for Medicare and Medicaid Services such as (a) designation by the State, (b) rural location, (c) location more than 35 miles from the nearest hospital, (d) 25 or less inpatient beds, (e) average length of stay of less than 96 hours excluding swing beds, and (f) 24-hour emergency care (Centers for Medicare & Medicaid Services, 2012). Connecticut, Delaware, Maryland, New Jersey, and Rhode Island do not have CAHs. The five states with the largest quantity of CAHs are Kansas, Iowa, Texas, Minnesota, and Nebraska. The geographic distribution of the CAHs is shown in Table 1 (Flex Monitoring Team, 2012).

Table 1. Distribution of CAHs by State

State	Frequency
Alabama	2
Alaska	13
Arizona	15
Arkansas	29
California	31
Colorado	29
Florida	13
Georgia	34
Hawaii	9
Idaho	27
Illinois	51
Indiana	35
Iowa	82
Kansas	83
Kentucky	29
Louisiana	27
Maine	16
Massachusetts	3

Table 1. Distribution of CAHs by State (Continued)

State	Frequency
Michigan	36
Minnesota	79
Mississippi	32
Missouri	36
Montana	48
Nebraska	65
Nevada	11
New Hampshire	13
New Mexico	8
New York	13
North Carolina	23
North Dakota	36
Ohio	34
Oklahoma	34
Oregon	25
Pennsylvania	13
South Carolina	5
South Dakota	38
Tennessee	17
Texas	79
Utah	11
Vermont	8
Virginia	7
Washington	38
West Virginia	18
Wisconsin	58
Wyoming	16

Note: Data as of 3/31/12

Survey Instrument and Measures

The survey instrument (Appendix A) was based on the HLC study (The Joint Commission, 2007) with modifications of the format or wording to enable the survey to be presented as an electronic survey through Qualtrics, which allowed for if/then movement through the questions based on the answer to each question.

Collection of Cultural and Linguistic Information

CAH representatives were asked to report how their organizations identify linguistic and cultural needs of patients upon admission. CAHs were asked if such information was included on initial admission forms or addressed in the initial assessment and documented in the medical record. Each respondent could check more than one option. A value of 0 was assigned to "none of the above" and for all other responses, a value of 1 was assigned if checked. A sum of total points could range from 0 (no information collected) to 13 (checked all information collection options).

Mechanisms to Meet Cultural and Linguistic Needs

CAH representatives were asked to report if their organizations used languages other than English in their informed consent and other written materials, what types and how often, specific language interpretation services were used, how cultural needs are addressed including addressing cultural needs in informed consent. Each respondent could check more than one option. A value of 0 was assigned to "none of the above," and for all other responses, a value of 1 was assigned if checked. For frequency of use, values were assigned as follows: never = 0, seldom = 1, sometimes = 2, often = 3, and always = 4 for each type of language interpretation service. We used an additive index of mechanisms where 0 indicated a hospital had no mechanisms to address cultural and linguistic needs and 56 indicated that each mechanism listed was always used.

Mechanisms to Ensure Cultural and Linguistic Information follow Throughout Continuum of Care

CAH representatives were asked to report if their organizations shared the patient's language and cultural needs across the entire continuum of care. Each respondent could check

more than one option for example language and cultural needs are flagged in patient record, language and cultural needs are coordinated by a patient advocate, or language and cultural needs are identified on patient identification wrist band or other form of patient identification. A value of 0 was assigned to "none of the above." For all other responses, a value of 1 was assigned if checked. A sum of total points could range from 0 (no information collected) to 10 (checked all mechanisms).

Non-White Populations

CAH representatives were asked to report their organization's percentage of population speaking specific languages. The percentage of patient population what were listed as any race/ethnicity other than White were counted at the percentage listed. A sum of total points could range from 0 (no or non-White patients) to 100 (all non-White patients).

Non-English Speaking Populations

CAH representatives were asked to indicate their organization's percentage of population in specific racial/ethnic categories. The percentage of patient population what were listed as any language other than English were counted at the percentage listed. A sum of total points could range from 0 (no non-English speaking patients) to 100 (all non-English speaking patients).

CLAS Specific FTEs

CAH representatives reported the number of full-time and part-time staff members in their organization with direct responsibility for CLAS. Full-time staff members were counted as the whole number provided. Part-time staff members were weighted at 0.5 times the number provided.

Employee CLAS Training

CAHs reported whether their organization offered CLAS training and whether interpreters were evaluated on their ability to communicate in another language (0 = no, 1= yes). A sum of total points could range from 0 (no written policies, no evaluation of interpreters on ability to communicate in another language, and no CLAS training offered) to 29 (interpreters evaluated on ability to communicate in another language and CLAS training offered to all categories of personnel).

Variety of Language Services Available

CAH representatives were asked to report what types and how often specific language interpretation services were used. Each respondent could rate more than one service on a frequency scale (never = 0, seldom = 1, sometimes = 2, often = 3, and always = 4.) A sum of total points could range from 0 (no language interpretation used) to 32 (all services are always available).

Written Plans and Policies for CLAS

CAH representatives were asked to report if they had written plans and policies for language and culture. They were also asked to report if they had policies for linguistic and cultural competency of staff. A value of 2 was assigned to all yes responses, a value of 1 was assigned to all "established process but no written policy" responses, and a value of 0 was assigned to all no responses. A sum of total points could range from 0 (no policies or plans) to 16.

Open-Ended Questions

Several questions on the survey had an open-ended text response field. CAH representatives could enter any other information they though pertained to the question or helped explain their answer.

Data Analysis

Statistical analyses was performed using SPSS Statistics 18. First, statistical tests and visual inspection of histograms were used to check if variables were normally distributed. Research questions were answered using Pearson's r parametric correlations and partial correlations.

RESULTS

Survey Administration and Response

The electronic survey link sent via National Rural Health Association's e-newsletter in late December 2012 and again in mid-January 2013 did not yield any responses. Next, a list of all 1,329 critical access hospitals (CAHs) in the US was obtained from CMS. Their CEOs, CNOs or other executives' names and email addresses were obtained from facility websites. Personal emails were sent to leaders of 1,116 CAHs (a letter template is shown in Appendix B). Some emails (13%) were returned as undeliverable. Between January 31, 2013 and March 13, 2013, an individual email was sent to 968 facilities with valid email addresses received one individual email with a follow-up reminder email approximately 10 days later, sent as a blind carbon copy (BCC) in batches of 10-50 addresses. There were 213 CAHs for which no email address was available and these facilities were not contacted. A follow up analysis indicated that contacted facilities and facilities that could not be contacted had an identical average number of beds (22.4 beds vs. 22.4 beds, respectively).

Of the 968 facilities with deliverable emails, 270 (27.89%) opened the survey and 183 (18.90%) responded to the first question. Complete survey responses were obtained from 78 (8.06%) of the contacted CAHs and were analyzed to answer research questions.

Descriptive statistics of the respondents completing the sample showed that 58.40% of the respondents were hospital CEOs while 16.10% of them were Vice Presidents of Nursing or Directors of Nursing. Over 95% of them do not speak a language other than English and 94.00% of respondents were White (non-Hispanic/Latino). The mean years of hospital experience of the

respondents was 27.41 years with a median of 29.00. Of the CAHs in the survey, 22.70% are accredited by The Joint Commission and 68% are certified by the State Department of Health.

Nearly all (91.04%) of patients served by CAHs that participated in this study speak English (median = 97.00%, SD =14.11, range = 0.00-100.00%). Seven percent speak Spanish and the remaining patients speak one of the following languages, in the order or prevalence: Russian, Vietnamese, Chinese, French or French Creole, Polish, and Korean. Also, most (82.60%) patients served by CAHs that participated in this study are White and not Hispanic/Latino (median = 90.00%, SD = 20.43, range = 0.00-100.00%). The remaining patients are Hispanic or Latino (10.75%), Black or African American (3.38%), American Indian or Alaskan Native (1.75%), or other ethnicities (1.52%).

The data show that most CAHs that participated in this study (85.80%) have a written patient care policy addressing the provision of language services in patient care, 10.40% had no written policy but had a process in place, and 3.80% had no policy or process. Concerning written patient care policy addressing the provision of culturally appropriate services in patient care, 51.30% had a policy in place, 23.70% had no written policy but did have a process in place, and 25.00% had no policy or process.

Language services provided and frequency of use of each type of service are shown in Table 2. Use of any type of trained interpreter for their limited English proficiency patients was reported as “always” for 43 of the 179 (24.03%) CAHs responding to the survey. Patient family members and friends were always used by three of the responding CAHs, while four reported always using untrained staff or volunteers. Five CAHs (2.79%) responding to the survey stated they never use interpreters for their limited English proficiency patients.

Table 2. Percent of CAHs Offering Language Services (n=179)

	Never	Seldom	Sometimes	Often	Always
Trained staff interpreter	62.0	11.2	8.9	11.7	6.1
Trained contract interpreter	56.4	19.6	11.7	6.1	6.1
Trained volunteer	69.8	18.4	7.8	3.4	0.6
Trained bi-lingual staff member	54.7	13.4	14.0	11.7	6.1
Trained telephone interpreter	11.7	22.9	25.1	24.0	16.2
Untrained bi-lingual staff member	62.0	16.2	15.1	4.5	2.2
Untrained volunteer	79.3	12.3	7.3	1.1	0.0
Patient family member or friend	17.9	29.6	33.5	17.3	1.7
Other	58.6	6.9	13.8	20.7	0.0

Inter-Correlations are shown in Table 3 below.

Table 3. Inter-Correlations among Study Variables

	Median	1	2	3	4	5	6	7	8	9
1. CLAS info collection	7.00	1 131	.330** 124	.408** 129	.090 130	-.021 129	.202* 116	.104 87	.410** 129	.108 131
2. Meet CLAS needs	17.00		1 141	.351** 139	.250** 128	.290** 127	.331** 118	.185* 87	.543** 130	.860** 141
3. Follow continuum of care	2.00			1 150	.093 135	.060 134	.191* 125	.132 87	.513** 137	.281** 150
4. Serve non-white population	10.00				1 138	.751** 137	.217** 121	.045 87	.131 134	.306** 137
5. Serve non-English population	4.00					1 137	.173* 120	-.012 87	.242** 133	.371** 136
6. Employ CLAS FTEs	0.05						1 128	.074 78	.266** 124	.247** 128
7. Provide CLAS training	8.00							1 89	.398** 88	.137 89
8. CLAS policies	6.00								1 139	.387** 139
9. Offer language services	8.00									1 179

Notes: * p > 0.05; ** p > 0.01

The first research question was: Is the collection of cultural and linguistic information from patients upon admission associated with the presence of mechanisms to meet these cultural and linguistic needs? There was a significant positive relationship between these variables, Pearson's r = .330 (*P < .001,* one-tailed). Next, the same relationship was tested controlling for the size of the non-English speaking population. A partial correlation was small in magnitude (r = .090) and not significant (*P = .238*), indicating that the relationship tested may be largely a function of the size of the non-English speaking population.

The second research question was: Is the collection of cultural and linguistic information from patients upon admission associated with the presence of mechanisms to ensure this information follows the patient throughout the continuum of care? A significant positive relationship (Pearson's r = .408, *P < .001*) was observed. It was smaller in magnitude but still positive and significant (r = .254, *P = .006*) when the size of the non-English speaking population was controlled. Therefore, the relationship between collection cultural and linguistic information from patients and mechanisms to ensure this information follows the patient throughout the continuum of care stands after removing variance associated with the size of the non-English speaking population.

The third research question was split into four parts. First, Do CAHs that have larger non-White populations have a greater number of employees with CLAS specific duties than CAHs that have smaller non-White populations? There was a significant positive relationship between the two variables, (Pearson's r = .217 *P = .009,* one-tailed). Second, Do CAHs that have larger non-English speaking populations have a greater number of employees with CLAS specific duties than CAHs that have smaller non-English speaking populations? The data suggest a significant positive relationship, Pearson's r = .173, *P =. 030,* one-tailed.

Third, Do CAHs that have larger non-White populations provide more CLAS specific training than CAHs that have smaller non-White populations? A one-tailed Pearson's r parametric correlation of .045 (*P = .340*) indicated that there is not a significant relationship between non-White population size and provision of CLAS specific training to CAHs' employees. Finally, Do CAHs that have larger non-English speaking populations provide more CLAS specific training than CAHs that have smaller non-English speaking populations? A one-tailed Pearson's r parametric correlation of -.012 (*P =. 455*) indicated a weak non-significant relationship.

The fourth research question was: Do CAHs that have larger non-English speaking populations have a greater variety of language services available and use them more often than CAHs that have smaller non-English speaking populations? A one-tailed Pearson's r parametric bivariate correlation of .371 (*P < .001*) indicated that there is a significant positive relationship between the variables of interest.

Conclusions and Discussion

CAHs that collect information at admission about the cultural and linguistic preferences of their patients had significantly more mechanisms in place to ensure that the CLAS needs of these patients are met. There was a significant positive correlation between collecting information at admission about the cultural and linguistic preferences of their patients and ensuring that these preferences are communicated throughout the continuum of care. The prevalence of Electronic Health Records (EHR) could play a role in allowing this information to be shared throughout the continuum of care. Data regarding the use of EHR in each CAH was not collected in the survey; therefore, the link to EHR cannot be verified.

Larger non-White and non-English populations were significantly and positively associated with the availability of language services. It seems intuitive that CAHs with larger LEP populations would offer more language services. However, the highest rate of interpretation listed as always or often was provided through patient friends and family members rather than trained personnel.

Serving a larger non-White or non-English speaking population was significantly associated with the hospitals' provision of employees with specific CLAS duties. However, this relationship was not replicated for provision of training and competency assessment of their staff members.

As noted earlier, there is much literature showing the disparity in care and outcomes between patients who used trained healthcare interpreters and untrained healthcare interpreters. Surprisingly, only 4.66% of the CAHs in this study reported that they always used trained interpreters for LEP patients and over 48% of the CAHs in this study reported never using interpreters (trained or untrained) for LEP patients.

Limitations

External validity may be threatened by somewhat small response rate and the fact that only one-half of respondents who opened the survey completed all questions. Moreover, findings may not be generalizable across all hospitals because of different languages and cultures represented by the patients that present to specific hospitals.

Implications for Practice

These findings may be useful to hospital executives in rural CAHs when making decisions on how to use the cultural, ethnic, and linguistic information that is collected at registration. A greater emphasis on providing mechanisms to ensure that CLAS needs of patients are met may be of value. Also, more programs to develop cultural and linguistic competencies among hospital employees and clinicians may be pertinent.

Opportunities for Future Research

Future researchers of CLAS services should examine why CAHs are not using trained personnel. In addition, the needs of CAHs who serve indigenous farm workers need to be examined in greater detail. Not all people from Central and South American speak Spanish as their first language. A factsheet regarding indigenous farmworkers states that the indigenous population from Mexico is made up of three different language groups (National Center for Farmworker Health Inc, 2011). Those groups tend to live in hometown networks because they share many cultures and traditions, including healing and health beliefs. High concentrations of these groups are found in California. CAHs in areas with indigenous farm workers may want to look at other cultures and languages that are common to people from Latin America. These CAHs would benefit from additional research regarding the cultural and linguistic needs of these indigenous groups.

Future researchers of CLAS could benefit from determining the definition of an encounter as it relates to language services and interpreters. For instance, a limited English-speaking patient is provided with service in multiple departments in the hospital, but an

interpreter is only used in some of those departments. Is the entire visit counted as one encounter and counted as having used an interpreter for the encounter?

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APPENDICES

APPENDIX A

SURVEY INSTRUMENT

This study uses the Office of Minority Health (OMH) definition of culturally competent healthcare: "services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations." For the purposes of this project, "culture" refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. "Translation" refers to the conversion of written communication from one language to another, while "interpretation" refers to the conversion of spoken communication from one language into another. Please answer the following questions honestly based on your hospital's services and administration. Remember, this is a baseline assessment and there is no right or wrong answer.

1. LANGUAGE SERVICES

The Joint Commission defines Language Services as mechanisms used to facilitate communication with individuals who do not speak or read English. These services can include in-person interpretation using a qualified interpreter, bilingual staff, or the use of remote interpreting systems such as telephone or video interpreting. Language services also refer to processes in place to provide translation of written materials or signage. Interpretation refers to the conversion of spoken communication from one language into another.

2. Does your hospital have written patient care policies that address the provision of **language services** in patient care?

a. ❑ Yes

b. ❑ There are no written policies, but an established process is in place

c. ❑ No

3. How does your hospital identify **language needs** of patients upon admission or registration? Select all that apply:

a. ❑ information included on admission forms

b. ❑ addressed in initial assessment and documented in medical record

c. ❑ other (please specify): _____

d. ❑ none of the above

4. How does your hospital's informed consent process address **language needs**? Select all that apply:

a. ❑ Written informed consent forms are available in the primary languages of our patients.

b. ❑ Interpreters are used in informed consent discussions with patients.

c. ❑ When interpreter is used, his or her signature is required on informed consent forms.

d. ❑ Multimedia formats of informed consent presentations (such as videos) are available in the primary languages of our patients.

e. ❑other (please specify): _____

f. ❑ none of the above

5. How does your hospital ensure that information about a patient's **language needs** is shared across continuum of care? Select all that apply:

a. ❑ language needs are flagged in the patient record
b. ❑ language needs are coordinated by patient advocate
c. ❑ language needs are coordinated by specific department/unit (please specify) _____
d. ❑ language needs are coded in a bracelet or other form of identification
e. ❑ other (please specify): _____
f. ❑ none of the above

6. How often does your hospital use the following types of **language services**?

	Not Available	Never	Seldom	Sometimes	Often	Always
a. trained staff interpreter	❑	❑	❑	❑	❑	❑
b. trained contracted interpreter	❑	❑	❑	❑	❑	❑
c. trained volunteer	❑	❑	❑	❑	❑	❑
d. trained bi-lingual staff	❑	❑	❑	❑	❑	❑
e. untrained bi-lingual staff	❑	❑	❑	❑	❑	❑
f. untrained volunteer	❑	❑	❑	❑	❑	❑
g. patients' family members/friends	❑	❑	❑	❑	❑	❑
h. telephone interpreter service	❑	❑	❑	❑	❑	❑
i. other (please specify): ____	❑	❑	❑	❑	❑	❑

7. Which of the following written materials are provided to patients in any **language other than English**? Select all that apply:

a. ❑ illness related education
b. ❑ wellness related education
c. ❑ community resources
d. ❑ patient rights
e. ❑ informed consent documents
f. ❑ discharge instructions
g. ❑ advance directives
h. ❑ patient signage
i. ❑ other (please specify): _____
j. ❑ none of the above

8. Which hospital plans address the patients' **language needs**? Select all that apply:

a. ❑ strategic planning
b. ❑ budget planning
c. ❑ disaster planning
d. ❑ other (please specify): _____
e. ❑ none of the above

9. How does your hospital allocate operating funds for **language services**?
a. ❑ A specific line item on the hospital's budget for language services
b. ❑ Part of another line item on the hospital's budget
c. ❑ No funds specifically for language services
d. ❑ other (please specify): _____

10. CULTURAL COMPETENCY
This study uses the Office of Minority Health (OMH) definition of culturally competent healthcare: "Services that are respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations." For the purposes of this project, "culture" refers primarily to characteristics of human behavior associated with race, ethnicity, and religion. Examples of cultural health beliefs and practices include: Not using the word cancer with Russian patients (Dohan & Levintova, 2007), or realizing that Amish patients may have used folk, herbal, and other types of alternative medicine prior to coming to the hospital (Henderson & Anbar, 2009).

11. Does your hospital have written patient care policies that address the provision of **culturally appropriate services** in patient care?
a. ❑ Yes
b. ❑ There are no written policies, but an established process is in place
c. ❑ No

12. How does your hospital identify **cultural needs of patients** upon admission or registration? Select all that apply:
a. ❑ information included on admission forms
b. ❑ addressed in initial assessment and documented in medical record
c. ❑other (please specify): _____
d. ❑ none of the above

13. Which of the following methods does your hospital use to address the **cultural needs of patients**? Select all that apply:
a. ❑ assess patient health literacy
b. ❑ assess patient cultural dietary restrictions (For example: Kosher foods for Jewish patients)
c. ❑ provide menu items that comply with cultural dietary needs
d. ❑ offer religion specific/sensitive services (for example: end of life rituals)
e. ❑ assess patient's use of folk remedies or alternative medicine treatments
f. ❑ use culturally competent individuals who broker relationships between patients and providers. (For example: individuals who are not word-for-word interpreters, but provide culturally sensitive communication with the patient and provider).
g. ❑other (please specify): _____
h. ❑ none of the above

14. Does your hospital's informed consent address any of these **cultural needs**? Select all that apply:

a. ❑ Use of blood products
b. ❑Use of tissue or organ products
c. ❑other (please specify): _____
d. ❑ none of the above

15. How does your hospital ensure that information about **cultural needs accompany the patient** throughout the continuum of care? Select all that apply:

a. ❑cultural needs are flagged in the patient record
b. ❑cultural needs are coordinated by patient advocate
c. ❑cultural needs are coordinated by specific department/unit (please specify) _____
d. ❑cultural needs are coded in a bracelet or other form of identification
e. ❑other (please specify): _____
f. ❑ none of the above

16. Which hospital plans address the patients' **cultural needs**? Select all that apply:

a.❑ strategic planning (example – education, community)
b.❑ budget planning (availability of religious services)
c.❑ disaster planning (example – notification if no telephone – Amish)
d.❑ other (please specify): _____
e.❑ none of the above

17. How does your hospital allocate operating funds for **cultural services**?

a.❑ A specific line item on the hospital's budget for cultural services
b.❑ Part of another line item on the hospital's budget
c.❑ No funds specifically for cultural services
d.❑ other (please specify): _____

18. Meeting CLAS Standards

19. Number of full-time staff member(s) with direct responsibility for managing **language** competency initiatives at your hospital: _____

20. Number of part-time staff member(s) with direct responsibility for managing **language** competency initiatives at your hospital: _____

21. Number of full-time staff member(s) with direct responsibility for managing **cultural** competency initiatives at your hospital: _____

22. Number of part-time staff member(s) with direct responsibility for managing **cultural** competency initiatives at your hospital: _____

23. How strongly do CLAS regulations influence your hospital's efforts to provide CLAS services? (1= not at all, 7 = very strongly) _____
Comment (text box)

24. HUMAN RESOURCES (HR) DEVELOPMENT

25. Does your hospital have written HR policies regarding **linguistic competency** of staff?

a. ❑ Yes
b. ❑ There are no written policies, but an established process is in place
c. ❑ No

26. Does your hospital have written HR policies regarding **cultural competency** of staff?

a. ❑ Yes
b. ❑ There are no written policies, but an established process is in place
c. ❑ No

27. Does your hospital offer CLAS training for any of the following groups:
Select all that apply:

	New Employee Orientation	Ongoing Training	Competency Assessment
a. Physicians	❑	❑	❑
b. other clinical staff (nurses, social workers, etc.)	❑	❑	❑
c. non-clinical (patient advocates, etc.)	❑	❑	❑
d. administrative	❑	❑	❑
e. facilities (food service, maintenance, etc.)	❑	❑	❑
f. senior management (managers, support staff, etc.)	❑	❑	❑
g. governing body	❑	❑	❑
h. residents and students	❑	❑	❑
i. other _____	❑	❑	❑
j. none of the above	❑	❑	❑

28. In your hospital, are interpreters evaluated on their ability to communicate medical information in languages **other than English**?

❑ Yes
❑ No

29. Does your hospital solicit employee feedback to help in the development of CLAS initiatives?

❑ Yes
❑ No

30. PATIENT POPULATION DEMOGRAPHICS

31. What patient specific information does your hospital gather related to **culture or language**? Please check all that apply.

a. ❑ race
b. ❑ education level
c. ❑ ethnicity
d. ❑ religion
e. ❑ patient's primary language
f. ❑ primary language of patient's family
g. ❑other (please specify): _____

32. What is the **racial/ethnic** breakdown of your patient population? Please select all that apply and include percentages where available. (Office of Management and Budget classifications used.)

a. _____% White (not Hispanic/Latino)
b. _____% Black or African American (not Hispanic/Latino)
c. _____% American Indian or Alaska Native
d. _____% Asian or Native Hawaiian
e. _____% other Pacific Islander
f. _____% Hispanic or Latino
g. _____% other (please specify): _____

33. What are the **primary languages** of your patient population? Please select all that apply and include percentages where available.

a. _____% English
b. _____% Chinese (Mandarin/Cantonese)
c. _____% French/French Creole
d. _____% Hmong
e. _____% Khmer (Cambodian)
f. _____% Korean
g. _____% Polish
h. _____% Portuguese
i. _____% Russian
j. _____% Spanish
k. _____% Vietnamese
l. _____% other (please specify): _____

34. SURVEY RESPONDENT DEMOGRAPHICS

The following questions ask information about YOU as the survey respondent. These questions are for statistical demographic purposes only.

35. What is your title or equivalent position in your hospital?

❑Chief Executive Officer/President
❑Chief Financial Officer

❑Chief Operating Officer/Controller
❑Compliance Officer
❑Vice President of Nursing/Director of Nursing
❑Multicultural Affairs Officer
❑other (please specify): _____

36. How many **years** of experience do you have in healthcare?

37. How long have you worked in this hospital _____ (years)?

38. What is your race/ethnicity?
a.❑White (not Hispanic/Latino)
b.❑ Black or African American (not Hispanic/Latino)
c.❑American Indian or Alaska Native
d.❑ Asian and Native Hawaiian
e.❑ Other Pacific Islander
f. ❑Hispanic or Latino
g.❑ other (please specify): _____

39. In what languages (other than English) do you consider yourself fluent?
a. ❑ Chinese (Mandarin/Cantonese)
b. ❑French/French Creole
c. ❑ Hmong
d. ❑Khmer (Cambodian)
e. ❑Korean
f. ❑Polish
g. ❑Portuguese
h. ❑Russian
i. ❑Spanish
j. ❑Vietnamese
k.❑other (please specify): _____
l. ❑ none of the above

40. Please share any additional thoughts and comments related to culturally and linguistically appropriate services (CLAS) standards related to your hospital or critical-access-hospitals in general. _____

41. If you are willing to spend 15-30 minutes in a follow-up phone conversation about this study, please list your contact information below:
Hospital Name:
Your Name:
Your phone number:
Your email address:

APPENDIX B

EMAIL TEMPLATE

Subject: Critical Access Hospitals and Culturally and Linguistically Appropriate Services

You may have seen an invitation in the January 17, 2013 issue of NRHA Today (http://www.multibriefs.com/briefs/nrha/nrha011713.php) asking all Critical Access Hospitals to participate in an on-line survey about Culturally and Linguistically Appropriate Services (CLAS). In order to effectively determine whether CAHs have diverse populations in their geographic service area and if so, what these hospitals are doing to ensure their employees are well trained in CLAS and their patients are receiving the appropriate services for their cultural and language needs, a survey of all Critical Access Hospitals (CAH's) in the country is being offered. Your response to this survey is crucial in providing the necessary information to compare how CAHs meet CLAS guidelines.

The survey can be accessed at the following link: https://purdue.qualtrics.com/SE/?SID=SV_0vKId0wHYTSI61f. It should take approximately 8-12 minutes to complete. Your response and time is greatly appreciated.

This study is being performed by Sheila Kelty, FACHE as a requirement of her Doctor of Health Administration degree at Central Michigan University. If you have any questions about this survey or study, please contact Sheila Kelty by email at kelty1sm@cmich.edu or by phone at 574-276-9942.

Thank you!

APPENDIX C

EXPANDED LITERATURE REVIEW

The literature review consists of peer-reviewed and scholarly journal articles. In order to locate appropriate articles, the Central Michigan University Off-Campus Library website was used to search the following databases: Health Business Fulltext Elite, ABI/INFORM, MEDLINE, and PUBMED Central. Search terms used include cultural competency, linguistic competency, professional-patient relations, healthcare disparities, language, interpretation, translating, communication barriers, emergency service, and hospital. Key journals in this field are *Journal of Health Care for the Poor and Underserved, Journal of Immigrant Minority Health,* and *The Journal of Emergency Medicine*.

The literature review focuses on the topics: CLAS, effects of language barriers among LEP patients in healthcare, identification of patients who need language assistance or have cultural needs, differences between modes of interpretation, health disparity by culture, and cultural competency in healthcare organizations.

The Joint Commission requires hospitals to meet standards that support cultural and linguistic needs of patients. One of these standards is that the patient's medical record contains information about the patient's language needs. Another standard is that the hospital provide information in a manner and language the patient can understand (The Joint Commission, 2009). A study of 60 hospitals revealed that the majority of the hospitals did not have a consistent method for collecting patient language data (The Joint Commission, 2007). In order to become a hospital that routinely provides CLAS, there must be an established and consistent method for collecting data regarding the race, ethnicity, and language of the patients.

Collection of language and cultural data such as race and ethnicity are key elements of meeting CLAS. Five hypotheses related to collection of patient cultural and linguistic data were identified for this study.

Hypothesis 1 - CAHs that collect cultural and linguistic information from patients upon admission have more mechanisms in place to meet these cultural and linguistic needs than CAHs that do not collect cultural and linguistic information from patients upon admission.

Hypothesis 2 - CAHs that collect cultural and linguistic information from patients upon admission have more mechanisms in place to ensure this information follows the patient throughout the continuum of care than CAHs that do not collect cultural and linguistic information from patients upon admission.

Hypothesis 3 - (a) CAHs that have larger non-White populations have a greater number of employees with CLAS specific duties than CAHs that have smaller non-White populations, (b) CAHs that have larger non-English speaking populations have a greater number of employees with CLAS specific duties than CAHs that have smaller non-English speaking populations. (c) CAHs that have larger non-White populations provide more CLAS specific training than CAHs that have smaller non-White populations, (d) CAHs that have larger non-English speaking populations provide more CLAS specific training than CAHs that have smaller non-English speaking populations.

Hypothesis 4 - (a) CAHs that have larger non-English speaking populations have a greater variety of language services available and use them more often than CAHs that have smaller non-English speaking populations , and (b) CAHs that have larger non-

White populations have a greater variety of language services available and use them more often than CAHs that have smaller non-White populations

Identification of language barriers

A study of Spanish and/or English speaking patients identified that LEP patients found that it was easy to identify patients who would benefit from a language interpreter based on the patient's responses to two questions regarding how well the patient spoke English and what language the patient preferred to receive his/her medical care (Karliner, et al., 2008). Such measures help hospitals identify those patients who truly need language services. In order to provide proper services the hospital must identify the language needs of the individual patient. Once the need for an interpreter is determined, it is important that the hospital staff know the proper use of the interpreter. The investigation of the attitudes and practices of hospital staff regarding the use of trained interpreters in one hospital determined that only nine percent of hospital's clinical staff had training in how to work with an interpreter (Hudelson & Vilpert, 2009). Most of these clinical staff members were not encouraged to use interpreters within their clinical department. Physicians tend to use their own limited foreign language skills to get by even when trained interpreters are available (Diamond, et al., 2009). These findings should be unsettling to hospitals who wish to satisfy Title VI of the Civil Rights Act of 1964 concerning providing language services for LEP patients.

Modes of Interpretation

In the absence of a language concordant provider, there are multiple options available for interpreter services in healthcare. Research shows that ad hoc interpreters are more likely to have negative clinical results compared to medically trained interpreters (Flores, et al., 2003). A comparison of ad hoc interpreters and over-the-phone interpreters (OPI) provided data to

support OPI as having a better patient/provider understanding, more ease of communication, and higher overall visit satisfaction (Cunningham, Cushman, Akuete-Penn, & Meyer, 2008). In an effort to determine the more favorable methods of professionally trained medical interpreters, many studies have been performed.

A common comparison is between proximate and remote interpretation, wherein the proximate person is either a language concordant clinician or a professionally trained medical interpreter and the remote interpreter is performing language interpretation over the telephone. A study of Spanish speaking patients in a pediatric ED in Denver revealed no significant difference in concordance of diagnosis or in level of patient satisfaction between proximate professionally trained medical interpretation and remote OPI (Crossman, Wiener, Roosevelt, Bajaj, & Hampers, 2010). Another study of Spanish speaking patients in a pediatric ED in Dallas showed patients using proximate, hospital trained interpreters had significantly higher satisfaction scores than those using OPI services or ad hoc interpreters (Garcia, Roy, Okada, Perkins, & Wiebe, 2004). Furthermore, in this study the satisfaction scores of the patients in the high scoring group mirrored those of English proficient patients. The results of a study of Spanish speaking patients in a walk-in urgent care facility in Denver showed that patients who used OPI had satisfaction levels that did not significantly differ from language concordant patients (Lee, Batal, Maselli, & Kutner, 2002). Additionally, this study found that patients who used family members or ad hoc clinic-provided interpretation did have a significantly lower level of patient satisfaction.

A hospital's multicultural service department is generally responsible for maintaining appropriate language services for the hospital. The third hypothesis relates to the percentage of non-English speaking patients and the percentage of non-White patients in the population in

relation to the establishment of a multicultural service department. Hypothesis 3 - CAHs that have larger non-White and non-English speaking populations have a greater rate of established multicultural service departments than CAHs that have smaller non-White and non-English speaking populations.

Health Disparity

Historically, language services have been the focus of studies related to CLAS. More recently, studies have included other aspects of CLAS. Disparity is a very big problem in health care. The prevalence of specific diseases is different in people of various ethnic backgrounds or socio-economic levels. Generally, these disparities have been studied as related to health literacy, education levels, and socio-economic levels. One study reviewed the role of ethnicity in health literacy as related to cancer screenings. This study reported that beliefs about a disease, including prevention and treatment, varied by culture (Shaw, Huebner, Armin, Orzech, & Vivian, 2009). Public health campaigns must consider these varying beliefs when determining how to reach their target audience. The campaigns should be directed to a specific race or culture.

Cultural competency

One article discussed barriers to cultural competency in health care organizations, especially as related to diversity in the senior leadership of these organizations. This article stated that hospital boards should hire CEOs who embrace diversity because these CEOs will create the strategic plan that will drive the organization in a direction that will make cultural competence a long-term commitment (Catillo & Guo, 2011). One question the board and CEO should ask when looking at cultural initiatives is "Does the board and C-suite represent my community" (Cordova, Beaudin, & Iwanabe, 2010). This question is important because a health

care organization can state that diversity and CLAS are priorities for the organization, but creating strategies and policies without putting them into practice in leadership and governance positions sends a mixed message. The move toward CLAS must include representation from the cultures and languages of the patient population throughout the organizational hierarchy, not just in low-level service positions.

Leadership that embraces cultural and linguistic diversity will have a trickle-down effect into areas such as recruitment, hiring, training, and overall hospital culture. One study found that when patients were able to choose their physician, blacks and Hispanics chose physicians of their own race and ethnicity (Saha, Taggart, Komaromy, & Bindman, 2000). The primary reasons given for these choices were ethnicity and language. Therefore, recruitment of physicians who are of the same ethnic and language groups of the patient population is a good starting place for health care organizations who want to become more aligned with their patient base. Recruiting ethnically and linguistically concordant health care workers requires a lot more work for the Human Resources department. First, they must determine the demographics of the patient base. Then, they must find where to advertise for these workers (Whitman & Valpuesta, 2010). Diversity in the workforce is not the only step to creating a culturally competent organization. This same study found that although hospitals reported having staff from diverse backgrounds, the staff were not trained to care for patients from diverse backgrounds (Whitman & Valpuesta, 2010). Once the diverse staff is hired, they must be trained and efforts for retention must begin. This includes training the existing staff to become more culturally competent.

Training is an on-going process. It is not something that can be done once, then forgotten. One study performed a pre-test for cultural competence, then provided training, and performed a post-test (Khanna, Cheyney, & Engle, 2009). This study found that participants

scored higher in the post-test. The participants then self-reported their interactions with patients. The resulting change was an increase in awareness of cultural needs of the patients, and the importance of asking the patients questions that were relevant to their culture. One researcher stated that cultural competency training does not have to be a stand-alone training course; it can be integrated into any training the hospital is performing as long as the trainer is trained in cultural matters (Weech-Maldonado, et al., 2012). Another study showed the how cultural competence training can become a continuous improvement initiative. The steps for continuous improvement are to create the strategy and goals, assess competencies and performance, design the cultural competency programs, implement the competency programs, review the outcomes and start the process over (Curtis, Dreachslin, & Sinioris, 2007). Training programs and initiatives cost money, yet many hospitals do not have money in their budget marked for CLAS initiatives.

The importance of cultural competency within the organization can be seen by the policies and procedures that are in place to address CLAS. Development and implementation of policies, procedures, and training plans show that a hospital is engaged in these activities from a leadership level. The final hypothesis relates to the relationship between written policies/procedures and the allocation of money to fund CLAS initiatives. Hypothesis 4 - CAHs that have written policies and procedures for CLAS allocate money to CLAS related services more often than CAHs that do not have written policies and procedures for CLAS.

Overall, the literature review shows that leadership, staffing, and language are key components to the cultural and linguistic competence of a health care organization. The HLC study also reviewed quality improvement, patient safety, provision of care, and community engagement as components to the cultural and linguistic competence of a health care

organization (The Joint Commission, 2007). The literature is clear that providing language services does not make a hospital culturally competent. Therefore, this researcher will survey CAHs throughout the nation to see how they are providing CLAS for their patients.

APPENDIX D

CONSENT FORM FOR ANONYMOUS SURVEYS

CMU
CENTRAL MICHIGAN UNIVERSITY

Study Title: Culturally and Linguistically Appropriate Services in Critical Access Hospitals
Research Investigators' Names and Departments: Sheila M. Kelty, DHA student; Dr. Lana Ivanitskaya, Department of Health Sciences

Contact information for researcher (and Advisor, if researcher is a student): Sheila Kelty email:kelty1sm@cmich.edu; Dr. Ivanitskaya email: ivani1sv@cmich.edu

Introductory Statement
As a leader in a critical access hospital, you are invited to take part in a nationwide study of Culturally and Linguistically Appropriate Services in Critical Access Hospitals. If you have any questions about this study, please contact Sheila Kelty, primary investigator.

What is the purpose of this study? The purpose of this study is to look at whether CAHs have diverse populations in their geographic service area and if so, what these hospitals are doing to ensure their employees are well trained in CLAS and their patients are receiving the appropriate services for their cultural and language needs .

What will I do in this study? Participation in this study is limited to answering the electronic survey that is available at the web link provided in the cover email you received. At the end of the survey you have the option to make your contact information available to the primary investigator for a possible follow up phone call. If you are interested in participating in the phone call, please list your name and contact information when it is requested.

How long will it take me to do this? This survey will take less than 15 minutes to complete.

Are there any risks of participating in the study? There are no risks involved in the participating in this survey.

What are the benefits of participating in the study? Participation in this survey allows the researchers to gather information from a larger sample of critical access hospitals in order to determine how critical access hospitals are providing culturally and linguistically appropriate services for their patients.

Will anyone know what I do or say in this study (Confidentiality)? Your answers will not be revealed to anyone other than the primary researcher. All data will be aggregated for statistical analysis. Results of this study may be submitted for publication in appropriate healthcare related

journals. Any data under the investigator's control will, if disclosed, be presented in a manner that does not reveal the subject's identity, except as may be required by law.

Will I receive any compensation for participation? There is no compensation for participating in this survey.

Is there a different way for me to receive this compensation or the benefits of this study? There is no compensation for participating in this survey.

Who can I contact for information about this study? If you have any questions about this survey, please contact Sheila Kelty by email at kelty1sm@cmich.edu or by phone at 574-276-9942.

You are free to refuse to participate in this research project or to withdraw your consent and discontinue participation in the project at any time without penalty or loss of benefits to which you are otherwise entitled. Your participation will not affect your relationship with the institution(s) involved in this research project.

My return of this survey implies my consent to participate in this research and I have been given an electronic copy of this form to keep for my records.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Institutional Review Board by calling 989-774-6777, or addressing a letter to the Institutional Review Board, 251 Foust Hall Central Michigan University, Mt. Pleasant, MI 48859.

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