

County of Los Angeles
Department of Health Services

cultural and linguistic competency standards

Developed by DHS Cultural and Linguistic
Competency Standards Work Group

Edited by
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SECTION I: INTRODUCTION

Los Angeles County Department of Health Services (DHS) Vision:

DHS will improve the provision of culturally-sensitive patient/consumer service in collaboration with the community, labor unions, and our public private partners. The workforce will reflect cultural diversity and demonstrate language and cultural competence. (1996)

DHS Diversity Mission:

...DHS is committed to delivering quality health care services and improving the health care status of the people of Los Angeles County.

DHS understands that a key quality of care issue for culturally diverse populations and persons with limited English proficiency is the provision of culturally and linguistically appropriate services. In the delivery of health care, all patients have the same rights regardless of race, ethnicity, national origin and limited English proficiency. DHS will establish systems that promote diversity and maintain cultural competency in the workplace; and will strive to create an environment that understands that staff, patient and community cultures, values and beliefs are vital to the provision of accessible, quality health care... (2003)

A. DHS Introduction

Message from Dr. Thomas L. Garthwaite, M.D., Director and Chief Medical Officer for the Los Angeles County Department of Health Services

The Department is pleased to present our new Cultural and Linguistic Standards. These standards will guide and enhance the quality of care we are able to offer to our culturally and linguistically diverse patients. Improving patient-provider communications is critical to improving health outcomes, and reports demonstrating the link between culturally and linguistically sensitive services and better health outcomes are referenced throughout this document.

There are ambitious goals embodied within these standards. It is the link to patient outcomes that adds urgency to our need to meet these standards. To be successful, we must create a cooperative environment within the department, and with our external partners to support this effort.

These standards reflect the thoughtful work of many and I especially commend the DHS Cultural and Linguistic Standards Work Group, and the Project Edit Team for their hard work and commitment.

Message from Fred Leaf, Chief Operating Officer for Los Angeles County Department of Health Services

The DHS Cultural & Linguistic Standards articulate what is required, and what is the right thing for DHS to do in providing services for one of the most diverse patient populations in the nation. These standards reflect the efforts of a diverse work group made up of DHS facility and program managers and clinicians, cultural and linguistic specialists, legal and language rights advocates, and other stakeholders committed to improving services to culturally and linguistically diverse patients. This will be an important and ongoing process that will help DHS become one of the leading public health systems in the provision of culturally and linguistically sensitive health services.

B. Purpose

These cultural and linguistic competency standards are established to assist DHS and its entities in creating a health system that is responsive and accessible to our culturally and linguistically diverse patient populations, and are in accord with all existing state and federal regulations. Some standards, however, exceed the existing requirements and demonstrate DHS' commitment to improving access to diverse populations. Implementation of these standards within the current environment of declining resources will be incremental and an ongoing process. DHS cultural and linguistic policies will be integrated into a comprehensive plan that includes needs assessment, training, monitoring, and language service provision to ensure that the policies are consistently followed throughout DHS and that patients can be assured of receiving appropriate care at key points of contact.

In 1999 the Director of Health Services established as a department goal the improvement of the effectiveness of the health care delivery system, and the establishment of systems that promote diversity and cultural and linguistic competency. This commitment is continued in the five departmental goals for 2003-04 of DHS Director and Chief Medical Officer Dr. Thomas Garthwaite, one of which is to reduce disparities in the provision of care and enhance cultural sensitivity across DHS.

C. Background

Los Angeles County, with over 9.5 million residents, is the most diverse and populous county in the United States and home to nearly a third of California's residents. The Los Angeles County Department of Health Services (DHS) is the second largest public health system in the Nation and is governed by the Los Angeles County Board of Supervisors. DHS provides health care services for county residents and serves as the major open door provider for the more than 1.7 million uninsured, of which over 300,000 are children. DHS treats some 800,000 patients annually; an estimated 600,000 which are uninsured. DHS provides 15% of all emergency visits in the County; and 50% of all trauma visits.

The challenges before the County include an increasing demand for services in the face of diminishing resources. However, DHS remains committed to protecting the health of, and providing quality health care to all County residents regardless of race, ethnicity, national origin, ability to speak English, or ability to pay. Recognizing the diverse cultures and languages of its patient population, DHS acknowledges that a key quality of care issue is the provision of culturally and linguistically appropriate services. A framework of organizational, structural, and clinical cultural competence interventions, including minority recruitment into the health professions, development of interpreter services and language-appropriate health educational materials, and provider education on cross-cultural issues can facilitate the elimination of disparities and improve care¹.

DHS Response to Cultural & Linguistic Diversity Issues

The Director of Health Services appointed 23 DHS staff and community leaders with expertise in this field to form a *Cultural and Linguistic Standards Work Group* in 1999. The group studied existing published cultural and linguistic standards and definitions, and current research, and considered the particular demographic and health needs of residents within Los Angeles County. The group also reviewed current laws and emergent legislation, and the requirements of state and federal funding and accreditation agencies. Finally, the Work Group reviewed current DHS policies relating to the cultural and linguistic needs of its diverse population.

By recognizing the diverse DHS constituency which makes up the service population, and integrating this knowledge into a new health care delivery system, DHS is positioning itself to address cultural and linguistic issues comprehensively and innovatively, in patient care and in its diverse workforce. If fully implemented, these Standards will provide an opportunity for LA County to develop national leadership in addressing cultural and linguistic competency in healthcare, a critical issue in most urban centers across the country. In June, 2002, the Los Angeles County Board of Supervisors instructed the Director of Health Services to finalize and integrate the Cultural and Linguistic Competency Standards within the Department's redesigned system.

A grant from the Center for the Health Professions of the University of California, San Francisco in 2003 made this document possible, allowing for the final editing of the standards and attachments. The editing team consisted of Niels Agger-Gupta, Ph.D., an independent consultant, as the principle editor, and Karin Wang, Esq., Vice President of Program Administration for the Asian Pacific American Legal Center, and Miya Iwataki, Director of the Office of Diversity Programs, LA County Department of Health Services.

Impact of Cultural Competency on Health Outcomes

Non English speaking patients in the USA are less likely to receive appropriate care; less likely to understand care instructions; have increased risk of medical errors; have reduced quality of care; have increased risk of unethical care; and are less satisfied with their care¹⁻⁷.

Cultural and linguistic issues impact quality of care and health outcomes on many levels. In 1998, President Clinton's "One America" Race Initiative identified six areas of racial and ethnic disparities in health in which the potential exists to prevent disease and disability: cancer screening and management, cardiovascular disease, child and adult immunizations, diabetes, HIV infection/AIDS, and infant mortality. Represented in the Los Angeles service population are large numbers of the specific populations in which the federal government has noted the greatest health disparities.

The National Academies Institute of Medicine (IOM) in its report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, found racial and ethnic disparities in health care even when insurance status, income, age, and severity of conditions were comparable.⁸ Evidence of racial and ethnic disparities in health is also, with few exceptions, remarkably consistent across a range of illness and health care services. Increasing awareness of racial and ethnic disparities in health care among the general public and key stakeholders is recommended as one strategy to address this issue.

The study also recognized that minorities experience a range of access barriers, including "barriers of language, geography, and cultural familiarity." It explained that language barriers pose a significant problem because it may affect "the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision making, or ethical compromises." (An overview of key studies relating to language barriers in health care appears in Appendix G of the full document.)

The Business Case for Culturally Competent Services

A study report issued by the National Health Law Program and the Henry J. Kaiser Family Foundation, has found that language barriers can cause doctors to rely on extensive, costly, often unnecessary tests, causing treatment to take 25-50% longer than treatment for English-speaking patients.⁹

The US Office of Management and Budget benefit-cost report on Executive Order 13166 discussed the benefits of providing language services, including possible decreases in the number and severity of misdiagnoses or other medical errors.¹⁰ Medical errors can be extremely costly (estimated between \$17 and \$29 billion annually).¹¹ Provision of language services to limited English-speaking patients could help reduce medical errors by increasing the quality of information a provider obtains regarding their patient's condition. It could also increase adherence to medical instructions.

Overall, research has shown that culturally and linguistically competent services contribute to: decrease in medical errors, increased patient satisfaction, improved primary and preventative care, decreased medical costs, improved patient comprehension of informed consent for treatment, improved communication between healthcare professionals and patients, and improved marketing to a major consumer demographic segment. A more detailed and referenced overview may be found in this section of the full document.

Demographics

The population of L.A. County is larger than that of 44 states and 147 countries with a vibrant and dynamic diversity unmatched by any major metropolitan region in the US. The more than 80 nationalities and up to 63 racial/ethnic/multiracial groups (2000 Census), and 83 languages plus numerous dialects spoken in the home (L.A. Unified School District 1999) have far-reaching implications for health care. MediCal has identified 11 threshold languages for Los Angeles County.

The 2000 Census found that 36.2% of those in L.A. County were born in another country. Nearly half (49.2%) of the county's households speak a language other than English at home.⁵⁹ Of these, 477,729 households are linguistically isolated – that is, no one 14 years of age or older speaks English. Twenty-six percent of Hispanics, 24.4% of African Americans, about 14% of Asian/Pacific Islanders, and 8.5% of whites have incomes that are below the 100% federal poverty level.(2000 US census).The ability to communicate and work effectively across these substantial cultural and linguistic differences is critical to improving the quality of health care in Los Angeles County. (See Appendix I of full document)

D. Summary of Relevant Laws, Policies and Accreditation Requirements

Health programs and services are required to provide culturally and linguistically competent care under numerous statutory, regulatory, contract and accreditation authorities. Many of these requirements have been in effect for years; other requirements have arisen more recently, driven by the continuing diversification of the U.S. and California populations. The laws, policies and requirements most relevant to DHS are listed below. *(A detailed summary of each may be found in the full document in Appendix C)*

Federal Laws, Policies and Enforcement

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000 et seq.)
- U.S. Department of Health and Human Services (HHS) Title VI regulations (45 C.F.R. § 80 et seq.)
- Presidential Executive Order 13166 (65 Fed. Reg. 50121 (Aug. 16, 2000))
- HHS Office for Civil Rights, Title VI LEP Guidance (68 Fed. Reg. 47311 (Aug. 8, 2003))
- Hill-Burton Act (42 U.S.C. § 291 et seq.)
- Medicaid, State Children’s Health Insurance Program (SCHIP) and Medicare statutes and regulations
- Federal categorical grant program requirements

National Standards On Culturally And Linguistically Appropriate Services In Health Care

- HHS Office of Minority Health, National Standards on Culturally and Linguistically Appropriate Services in Health Care (65 Fed. Reg. 80865-79 (Dec. 22, 2000))

California Laws and Policies

- Government Code § 11135
- Kopp Act (Health & Safety Code § 1259)
- Dymally-Alatorre Bilingual Services Act (Gov’t.Code § 7290 et seq.)
- California Department of Health Services, Medi-Cal Managed Care Division, Medi-Cal Managed Care Contract Requirements
- Managed Risk Medical Insurance Board, Healthy Families Contract Requirements

Health Accreditation Requirements

- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Standards
- National Committee for Quality Assurance (NCQA) Standards

Healthcare professionals, including physicians, nurses, psychologists, and medical educators, among many, have also adopted standards for their members for cultural and linguistic competent care.

SECTION II: CULTURAL AND LINGUISTIC STANDARDS

Definition of Cultural & Linguistic Competency in Health Care for Organizations & Individuals

A working definition is one that addresses concrete steps to be taken in our daily work. Within this framework, the following definitions are offered:

Cultural Competency

Refers to a set of congruent behaviors, attitudes, policies, practices and beliefs that create and foster a professional and organizational culture that enables health care providers and organizations to:

- Recognize and acknowledge the diverse groups within the service population;
- Understand the role of diverse values, norms, practices, attitudes and beliefs about disease and treatment in program and policy development and health services planning;
- Enhance accessibility to services by diverse groups by improving cultural and linguistic competencies and availability;
- Take a holistic view of health, inclusive of cultural health beliefs and practices, and the physical, mental and emotional aspects of diverse groups;
- Respect and support the dignity and perspectives of the client, patient, family and staff to best address the health interests of the patient;
- Ensure systems of recruitment, evaluation, staff development and retention that support an organizational culture and staff that are better able to provide health services that meet the cultural and linguistic needs of the community;
- Measurably improve the health status of the populations and communities served.

Linguistic Competency:

A key component of cultural competency is linguistic competency, which refers to the health care organization's ability to provide its non- and limited English speaking patients with timely, accurate and confidential interpreting services, and quality, culturally-appropriate translated materials.

A. CULTURAL & LINGUISTIC ORGANIZATIONAL STANDARDS

STANDARD 1: CULTURAL COMPETENCY

STANDARD: The Department of Health Services (DHS) is committed to diversity as an integral component of its mission and values and to cultural competence as an organizational standard, and promotes the development of cultural competency skills within its workforce. As an organization, DHS will ensure that cultural competence is included where appropriate in policy and/or program planning, implementation and evaluation. Cultural competency will be a Performance Evaluation component for all DHS programs and managers.

DHS strives towards the principles of universal respect and dignity for all who enter its facilities and participate in its programs, and fosters an attitude of openness to perspectives that are new or different.

DHS recognizes the integral relationship between C&L competency and clinical effectiveness, improved health outcomes, patient /clinician rapport, and may potentially reduce overall costs of providing health services to LA County's diverse populations.

STANDARD 2: ORGANIZATIONAL ACCOUNTABILITY

STANDARD: The DHS commitment to C&L competence is system-wide and articulated by written DHS policies, practices, procedures and programs. DHS leadership models and promotes cultural competence as an active part of the DHS organizational culture, and will develop and/or provide the necessary professional development training to staff in these areas.

DHS leadership, including all managers, is accountable to the public in matters of legal compliance and accreditation requirements, and for the department's policy on C&L competence. DHS leadership is committed to ensuring that C&L policies are administered and implemented consistently across the department with guidance from the Office of Diversity Programs.

DHS leadership will involve diverse sectors of the community in the planning, ongoing feedback and evaluation of programs and services.

STANDARD 3: EXPECTATIONS OF DHS EMPLOYEES & CONTRACTORS

STANDARD: All individuals working at DHS facilities and programs, Public Private Partners, and other contracting entities providing health care services should aspire to carry out their duties in a manner consistent with the definitions and organizational expectations for C&L competency. These expectations seek to clarify the knowledge, skills, attitudes, and practices as tools for staff to provide culturally and linguistically competent health care services to the diverse patient population of Los Angeles County and to work effectively with other staff in the workplace.

Staff should have opportunities for continual skills building, including a range of professional development workshops, trainings, and new staff orientation including the mission, vision and values of DHS.

B. SYSTEMS FOR ENSURING LINGUISTIC ACCESS

STANDARD 4: ASSESSING LANGUAGE NEEDS

STANDARD: Each DHS facility or program will ask patients for their preferred written and spoken language, and whether they need an interpreter at any point where the patient presents for patient care, including telephone calls. The patient's primary/preferred language will then be recorded in the patient's medical record, with this data maintained as a required field in the facility information system.

When facility or program staff place or receive a telephone call and cannot determine what language the person on the line is speaking, bilingual staff, onsite interpreters or a telephone interpreting service will become involved in making an expedient determination.

STANDARD 5: COMMITMENTS FOR INTERPRETER SERVICES

STANDARD: All LEP patients seeking services at DHS facilities are entitled to qualified oral interpreting at no cost, regardless of language. Each DHS facility will maintain sufficient interpreter resources such as bilingual staff, staff interpreters, contracted interpreters from outside agencies, telephone interpreting services, and credentialed volunteers, to ensure a timely response when interpreters are needed. Minors may not be used to provide interpreting services except in life-threatening situations. Clinicians will receive professional development coaching on how to work effectively with a qualified interpreter.

Signage: The facility will post and maintain a sign, similar in size and legibility to the Hill-Burton Community Service notices supplied by HHS under the provisions of 42 C.F.R. '124.604(a), informing the public of the availability of interpreter services at all points of contact. The sign, in at least the threshold languages for Medi-Cal Managed Care, will say: "You have the right to an interpreter at no cost to you. Ask at the front desk." A "Point to Your Language" card in, at least, the MediCal threshold languages will be maintained at the points of contact.

STANDARD 6: QUALIFICATIONS FOR INTERPRETER SERVICES

a) Staff Interpreters:

STANDARD: All staff providing interpreting services to patients will be qualified, trained, tested and monitored by a DHS approved program to determine competency to provide interpreter services in health care settings. A qualified group of stakeholders including experts within the field of medical interpreting services, key DHS staff, and a union representative will advise on the development of this program which will include a curriculum for training bilingual staff in the role of interpreters. Recruitment and placement of interpreters and translators should be based on resource availability of qualified interpreters.

b) Non-staff Interpreters:

STANDARD: Non-staff interpreters may include outside interpreting services or telephone interpreting services. The facility should investigate and use those services whose standards, protocols, evaluation and training is similar to that expected of staff. When staff at the facility, or the LEP person, has reason to believe that an interpreter is hampering effective communication, staff shall obtain another interpreter.

STANDARD 7: WRITTEN TRANSLATIONS

STANDARD: All DHS vital documents should be translated into the identified Medi-Cal threshold languages for Los Angeles County. DHS staff responding to LEP persons making inquiries regarding English language documents should access bilingual staff or request an interpreter for assistance.

- Signage and way-finding directions
- Patient intake forms
- Consent forms for, but not limited to, the following examples: medical treatment, surgery, anesthesia, inpatient psychiatric treatment, and diagnostic tests
- Advance directives
- Patient complaint forms
- Letters and notices pertaining to the reduction, denial or termination of services or benefits
- Letters or notices that require a response from the beneficiary or client
- Documents that advise of free language assistance
- Information on emergency health issues
- Patient rights and responsibilities
- Billing and financial information
- General information on current clinical trials being conducted within the facility and opportunities to participate
- Applications for federal/state health and social services programs, including financial assistance
- Consents to release medical information
- Appointment reminder notices
- Key Health education materials
- HIPAA Privacy Notice.

Other written materials will be translated when it is determined that a printed translation is needed for effective communication. If there is no translation for an English language document, or the LEP patient/client cannot read the translated version, a qualified interpreter will orally sight translate the document for the LEP individual whenever possible.

An **Interpreter Attestation Form** must be completed when an interpreter is interpreting a discussion between a patient and a physician relating to a medical procedure, particularly for the purpose of obtaining an informed consent for treatment, and/or the sight/oral translation of the written information contained on the informed consent form in the presence of the healthcare provider. This form will be signed by the interpreter verifying that the information was interpreted. The signed Form will be attached with the consent to the medical record.

English language documents not deemed vital will include a notice written in the MediCal threshold languages to contact the facility if reading assistance is needed.

C. CULTURAL & LINGUISTIC OPERATIONAL STANDARDS

STANDARD 8: CULTURAL/LANGUAGE ACCESS MONITORING AND RECORD KEEPING

STANDARD: DHS and its entities will monitor the implementation of the DHS C&L policies on an on-going basis, and maintain updated records of patients' race/ethnicity, primary/preferred language, and the interpreting provided. All facilities and programs will report patient /client C&L data as a standard part of their DHS reporting. The reporting system will be standardized among DHS entities using compatible data and reporting format. The monitoring of cultural and language access will require interdepartmental cooperation; maintaining program and facility records will be coordinated by the LEP Administrators with overall coordination by the Office of Diversity Programs (ODP).

STANDARD 9: CULTURAL & LINGUISTIC COMPETENCY TRAINING

STANDARD: DHS will provide the necessary tools, skills and knowledge to support and improve culturally competent practices. This includes creating a workplace environment that empowers staff to work comfortably and effectively across the C&L boundaries presented by patients/clients and with other DHS staff.

DHS should develop and provide training opportunities for staff and senior management, as well as to physicians, nurses, allied technologists and other clinicians and providers, on diversity and C&L competency. These trainings should include the linkage between C&L care and improved health outcomes, legal requirements and policies including the DHS Standards, quality of care issues, and the importance of the skilled use of qualified interpreters, and information about the programs and services of the ODP. DHS staff, at all levels, have the responsibility to avail themselves of training programs and practices that promote culturally competent care.

STANDARD 10: HEALTH FACILITY STAFFING

STANDARD: DHS will work to build a workforce able to address the C&L needs of our patients, and to provide appropriate and effective services as required by federal, state and local laws, regulations and policies. DHS will promote a system of recruitment and retention of qualified staff from diverse backgrounds who understand their patient cultures and communities in order to support an organizational culture that can better serve the community. Training opportunities to increase C&L competency skills will be made available to assist staff with responsibilities for direct patient care.

DHS will annually assess the organization's progress in recruitment, hiring and retention of qualified bilingual and bicultural employees. Human Resource managers within DHS should assess and report on employee promotions, terminations and resignations, including the use of exit interviews, to evaluate how well the organization is doing in the promotion and retention of a diverse work force.

STANDARD 11: COMPLAINT/GRIEVANCE PROCESS

STANDARD: DHS will develop and implement a process to ensure a prompt and equitable resolution of complaints or grievances addressing its provision of culturally and linguistically appropriate services, and will monitor such complaints and their resolution. As part of its patient satisfaction efforts, DHS provides various complaint/grievance mechanisms to facilitate communication and problem resolution within its organization.

DHS entities will maintain a log of cultural and language complaints and the record of complaint resolution. This will be included in the facility's required complaint report issued quarterly and sent to the DHS Quality Improvement (QI) with a copy to the ODP. Aggregate data submitted to Quality Improvement and the ODP will be subject to an annual review. An annual report of all cultural and language access complaints will be prepared by the LEP Administrators and provided to the ODP and QI which will prepare a department-wide annual report, using aggregated, de-identified data to safeguard patient confidentiality.

SECTION III: SUGGESTED PROTOCOLS FOR STANDARDS IMPLEMENTATION

This section in the full document includes suggested program steps and protocols for each of the standards.

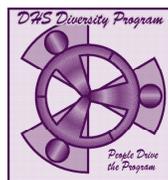
SECTION IV: APPENDICES

The appendices in the full document include:

- A listing of the Work Group Guiding Principles for the DHS C&L Standards
- A summary of current DHS policies addressing cultural and linguistic issues
- The National CLAS Standards on Culturally & Linguistically Appropriate Services in Health Care
- Federal and state laws and accreditation requirements
- Recommended topics for cultural & linguistic competency training for clinicians
- Executive summary of CHIA's California Standards for Healthcare Interpreters
- Research on language barriers in health care
- A glossary of terms used in the document
- LA County language & cultural data by Service Planning Area (SPA)
- A listing of the Cultural & Linguistic Work Group
- CA MediCal Threshold Languages
- Citations and references.

SECTION V: REFERENCES

1. Wirthlin Worldwide. *Hablamos Juntos / Survey of Interpreter Need*. Washington, D.C.: Robert Wood Johnson Foundation; December 12, 2001 2001. available online at: http://www.hablamosjuntos.org/mediacenter/press_conference.asp. Accessed 3/30/03.
2. Andrulis D, Goodman N, Pryor C. *What a difference an interpreter makes: Health care experiences of uninsured with limited English proficiency*. Boston, Massachusetts: The Access Project, a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University; 2002.
3. Gandhi TK, Burstin HR, Cook EF, et al. Drug complications in outpatients. *Journal of General Internal Medicine*. 2000;15:149-154.
4. Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services? *Journal of General Internal Medicine*. 1997;1997(12):472-477.
5. Diehl AK, Westwick TJ, Badgett RG, Sugarek NJ, Todd KH. Clinical and sociocultural determinants of gallstone treatment. *The American Journal of the Medical Sciences*. 1993 Jun;305(6):383-386.
6. Haffner L. Translation is not enough -- Interpreting in a Medical Setting. *Western Journal of Medicine*. 1992;157(3 (special issue on Cross-cultural Medicine: A Decade Later)):255-259.
7. Carrasquillo O, Orav EJ, Brennan TA, Burstin HR. Impact of language barriers on patient satisfaction in an emergency department. *Journal of General Internal Medicine*. 1999;1999(14):82-87.
8. Smedley BD, Stith AY, Nelson AR, eds. *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: Institute of Medicine, National Academy Press; 2002.
9. Perkins J, Simon H, Cheng F, Olson K, Vera Y. *Ensuring linguistic access in health care settings: Legal rights and responsibilities* (Revised August 2003). Los Angeles, California: National Health Law Program and Henry J. Kaiser Family Foundation. (available from The California Endowment, www.calendow.org and <http://www.NHeLP.org>); 2003, 1998.
10. Office of Management and Budget. *Assessment of the total benefits and costs of implementing executive order No. 13166: Improving access to services for persons with limited English proficiency (Report to Congress)*. Washington, D.C. March 14 2002.
11. National Academy of Sciences. *To err is human: Building a safer health system: Report to National Academy of Sciences*. Washington, DC: National Academy Press; 1999.



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