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A. POLICY STATEMENT

The Office of Mental Health is committed to developing and maintaining mental health services that are culturally competent, consumer-guided and community-based. Cultural and linguistic competence is an important factor in the effective delivery of services to the diverse populations in New York State.

Culture affects a person's health and mental health beliefs, practices, behaviors, and even the outcomes of interventions. A person's health behavior is based on how one understands the cause of illness. In mental health and medicine, research has shown that culturally-appropriate care improves diagnostic accuracy, increases adherence to recommended treatment, and reduces inappropriate emergency room and psychiatric hospital use.

Furthermore, the Office operates inpatient, residential, and outpatient programs which serve a large number of limited English proficient (LEP) patients and their families. Ensuring clear and effective communication in these programs is essential to the provision of quality care.

On October 6, 2011, Governor Cuomo signed Executive Order No. 26, which acknowledged that the public safety, health, economic prosperity, and general welfare of New York residents is furthered by increasing language access to State programs and services, and codified the State's commitment to ensuring that language access services are implemented in a cost effective and efficient manner. The Executive Order requires State agencies that provide direct public services to offer interpretive services and to develop language access plans.

The purpose of this policy directive is to advance the health, safety, and welfare of individuals receiving services in State-operated psychiatric facilities by assuring that each facility develops, implements and monitors a strategic workplan to promote care that is culturally sensitive and linguistically competent. In addition to fulfilling the directives of Executive Order No. 26, the ultimate goal of such a workplan is to eliminate culturally based disparities in the provision and quality of mental health care.

This policy directive shall apply to all programs under the auspices of State-operated psychiatric facilities.

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B. RELEVANT STATUTES AND STANDARDS

Executive Order No. 26 (October 6, 2011)

Americans with Disabilities Act (Pub. L. 101-336, 104 Stat. 327, 42 U.S.C. 12101-12213 and 47 U.S.C. 225 and 611).

14 NYCRR §527.4

Comprehensive Accreditation Manual for Hospitals (CAMH) and the Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)

CAMH standards

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) (Federal Register, Vol. 65, No. 247, pp. 80865-80879, December 2000)

Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §701 et seq)

Title VI of the Civil Rights Act of 1964 (Pub L.88-352, 78 Stat.241)

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. (The Joint Commission, 2010)

OMH Official Policy Directive PC 520 - Inpatient Programs

OMH Official Policy Directive PC-620 – Pastoral Care Services

OMH Official Policy Directive PC-450 – Procedures following the Death of a Patient

C. DEFINITIONS FOR the purposes of this policy directive:

- 1) **Bilingual staff** means individuals employed by the facility who have some degree of proficiency in more than one language.
- 2) **Cultural and linguistic competence** means the ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to a health care encounter.
- 3) **Culture** means integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- 4) **Interpreter** means a person who renders a message spoken/signed in one language into one or more languages.
- 5) **Language services** means mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency,

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and those who are deaf or hard of hearing. These services can include in-person interpreters, bilingual staff, or 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.

- 6) **Limited English Proficiency (LEP)** means the inability to speak, read, write, or understand English at a level that permits an individual to interact effectively with healthcare providers or social service agencies without the assistance of an interpreter.
- 7) **Qualified interpreter** means a specially trained professional 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 in the medical/mental health setting with skill and accuracy while adhering to the National Code of Ethics and Standards Practice published by the National Council on Interpreting in Health Care.
- 8) **Surrogate Decision-Maker** means an individual with legal authority to make decisions on behalf of a patient.
- 9) **Translator** means a person who converts written text in one language into another language.
- 10) **TTY** means a keyboard-type electronic device, also known as TDD or TT, which is capable of transmitting and receiving messages from another such device over the telephone or computer.

D. GENERAL PRINCIPLES

- (1) Cultural, religious, or spiritual beliefs can affect an individual's perception of illness and how he, she, and/or his/her family regard, receives and participates in health care.
- (2) A culturally competent organization is committed to establishing programs that address the needs of different patient populations. The culturally competent organization fosters a culture of openness and respect, by encouraging staff to:

- (a) value diversity;
- (b) assess them;

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- (c) manage the dynamics of difference;
 - (d) acquire and institutionalize cultural knowledge; and
 - (e) adapt to diversity and the cultural contexts of individuals and communities served.
- (3) Cultural competence is the ability to provide individualized care that accounts for the influences and benefits of the patient’s culture.
- (4) Effective communication is an essential component of quality care and patient safety. The accuracy of assessment and the effectiveness of treatment are contingent upon effective communication. Successful communication takes place:
- (a) when providers understand and integrate information obtained from patients; and
 - (b) when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.
- (5) Effective communication, cultural competence, and patient/family centered care practices should be embedded into the core activities of each facility’s system of care delivery to ensure that all patients receive the same high quality care¹.
- (6) Annual training and education is an important tool in achieving a culturally competent organization.
- (7) In accordance with Section G of this policy directive, each facility shall develop and implement a strategic workplan designed to facilitate cultural and linguistic competence

¹ The Joint Commission has incorporated these elements into its standards of care for hospitals and behavioral healthcare organizations and has published a monograph to encourage hospitals to integrate concepts from the fields of communication, cultural competence, and patient- and family-centered care into their organizations in the interest of advancing cultural competence and family-centered care. The Joint Commission “*Roadmap for Hospitals*” can be found at:
<http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf> 

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within its system of care. Such plan shall be designed to fulfill the requirements of Sections E and F of this policy directive.

E. REQUIREMENTS FOR LINGUISTIC COMPETENCE AND LANGUAGE SERVICES

(1) Each facility shall take reasonable steps to ensure that all Limited English Proficient (LEP) patients and surrogate decision-makers are able to understand their health/mental health conditions and treatment options, so that quality patient care is provided to their LEP patients.

- (a) The overall quality and level of services provided to persons who are LEP, deaf or hard-of-hearing shall be equal to that made available to all other patients.
- (b) Each facility must have TTY and assistive listening devices available;

(2) No facility shall deny care and treatment to, or otherwise discriminate against, persons who are Limited English Proficient, deaf or hard-of-hearing. All facilities operated by the Office of Mental Health must be in compliance with applicable laws and regulations governing language access, including but not limited to the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, and 14 NYCRR §527.4.

(3) Patients/surrogate decision-makers who are Limited English Proficient shall have all significant health/mental health services provided to them in their primary language or have interpreter services provided to them during the delivery of such services. Interpreter services shall be available within a reasonable time, at no cost to patients/surrogate decision-makers.

(a) In a treatment setting, effective communication is essential in the provision of medical, nursing and ancillary services, where patient safety, accurate medical care, and ability to understand treatment options are affected, (provided, however, that necessary emergency care or emergency safety interventions should not be withheld for any reason). Some examples of encounters and procedures which should be given priority in terms of facilitating effective communication are:

- (i) obtaining medical and mental health histories;
- (ii) explaining any diagnosis and plan for treatment;

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- (iii) explaining any change in regimen or condition;
- (iv) explaining any medical procedures, tests or surgical interventions;
- (v) explaining patient rights and responsibilities;
- (vi) developing individual crisis prevention/calming plans and explaining the use of seclusion or restraints;
- (vii) obtaining informed consent;
- (viii) providing medication instructions and explanation of potential side effects;
- (ix) explaining discharge plans; and
- (x) discussing advanced directives.

(b.) Language interpreting options can be flexible, and may include facility employed language interpreters, contract interpreting services, or trained bilingual staff, and may be provided in person or via telephone or video(e.g.: NYS Office of Mental Health’s Interpretalk and Language Bank Directory Services).

(c) When interpreter services are needed or requested by a patient, interpreters supplied or identified by the facility shall be utilized, provided, however, that upon the express request of the patient, a family member or significant other can serve as an interpreter provided that he or she is capable of adequately conveying medical and clinical information and concepts, the arrangement is clinically appropriate, and the patient has been informed of the option of using an alternative interpreter identified by the facility.

(1) In such cases, whenever feasible and appropriate, the facility shall additionally utilize bilingual staff or other interpreter to participate in the exchange to ensure that it represents an accurate portrayal of the information to facility staff and patients.

(2) The use of a family member(s) as an interpreter at the request of the patient must be documented in the patient’s record, and shall identify all other alternative interpreters that were presented to the patient.

² Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.

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and shall strive to communicate with the patient during the provision of care,

- (a) Treatment plans for persons who are LEP, deaf or hard-of-hearing, or who, for any cause, are unable to read or write, shall identify any significant related impact on such persons' functioning and treatment, and identify associated recommendations for treatment, including any reasonable accommodations.
- (b) For patients who are minors or incapacitated, and for family members, support persons and surrogate care givers involved in the recipient's treatment planning and care, the language needs of the patient's parent(s), guardian(s), family member(s), support person(s) or surrogate decision-maker(s) should also be determined, noted in the clinical record and communicated to staff.
- (5) The use of qualified interpreters and translators must meet the requirements of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. The hospital shall define staff qualifications specific to their job responsibilities.
- (6) The translation of facility written materials in frequently encountered or other languages shall be at the discretion of each facility, based on the patient population served. Priority should be given to critical documents that contain information for accessing facility services, such as informed consent documents, information releases, complaint forms, and intake forms with the potential for important health consequences. Such documents, if not produced in a written translation, shall be verbally translated to the patient or surrogate decision-maker. The provision of verbal translation of such documents shall be documented in the clinical record.

F. REQUIREMENTS FOR CULTURAL COMPETENCE AND PATIENT AND FAMILY CENTERED CARE

- (1) Facility efforts to develop culturally competent care should primarily focus on those cultures most frequently represented by the patient population they serve, with particular attention to cultures whose:
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(a) understanding of health, mental health, illness, or disability is sufficiently different from the mainstream to create a risk of substandard service as a result;

(b) family customs, social patterns, child-rearing practices, and religious values are sufficiently different from the mainstream to create a risk of inaccurately assessing family functioning;

(c) whose primary language is not English or whose means of communication is sufficiently different from mainstream as to risk misunderstanding essential elements of the clinical or professional interaction; or

(d) whose history of experiencing war or ethnic, racial, social, or class-related discrimination is likely to have produced trauma or stressors beyond the norm.

(2) Facilities shall provide effective, understandable, and respectful services that are provided in a manner compatible with cultural beliefs and practices, whenever possible and practical. The physical environment should, to the extent possible, acknowledge and welcome people from diverse cultural backgrounds and utilizes navigational signage that is likely to be widely understood by patients.

(3) The planning and provision of care, treatment, and services shall consider the patient's personal values, beliefs, and preferences which reflect his or her cultural, ethnic and/or religious heritage.

(4) Training. Each State-operated facility or program shall offer between two to four hours annually for cultural and linguistic competence professional practice and/or skill development, depending on the results of its self assessment performed in accordance with Section G of this policy directive.

G. STRATEGIC WORKPLAN

(1) Each State-operated psychiatric hospital, and program under the auspices of a State-operated facility, shall ensure that a strategic workplan is developed and implemented. Once developed and implemented, facilities shall thereafter review the workplan on an annual basis to review and measure progress and identify areas where continued improvement is needed.

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(2) The strategic workplan may be incorporated in the facility’s comprehensive strategic plan, or it may be a discrete plan.

(3) The strategic workplan must outline facility needs and strategies to address those needs, in relation to establishing and promoting effective communication, cultural competence, and patient and family centered care. It is anticipated that workplans may vary across State operated facilities, depending on the unique needs of each facility, and the extent to which cultural competence and patient and family centered care have already been incorporated in facility operations.

(4) The strategic workplan must identify and plan for annual cultural competence training that meets the facility’s needs. Such training can be provided by the Central Office Bureau of Cultural Competence at the request of the facility.

(5) Plan development process.

(a) The first step in the development of the strategic workplan is a self assessment To facilitate a standard approach statewide, facilities should assess their readiness and needs by utilizing the checklist found in the Joint Commission publication : ***“Effective Communication, Cultural Competence, and Patient-and Family-Centered Care Through Organization Readiness: Road Map for Hospitals,”*** attached hereto as Appendix A, or any subsequent revision thereof

(b) The results of the self assessment shall be utilized as the foundation for the strategic workplan. Such workplan should focus on advancing effective communication, cultural competence, and patient and family centered care, by identifying direction and methods to begin or improve upon facility efforts to meet the unique needs of its patients. Because size, setting, and resources affect a facility’s ability to create new services or modify existing programs, it is recognized that there is no standardized approach to these issues.

(6) The strategic work plan must identify and plan for annual cultural competence training that meets facility needs. The Central Office Bureau of Cultural Competence is available to assist each facility in fulfilling its training needs.

(7) Facilities may establish an internal task force or committee that will be responsible for establishing and promoting the initiative for advancing effective communication, cultural competence, and patient- and family-centered care, and for monitoring progress in achieving the goals established in the strategic workplan.

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H. ADDITIONAL RESOURCES

(1) The OMH Bureau of Cultural Competence has developed comprehensive training curricula on the importance of infusing cultural and linguistic competence throughout agency policies and clinical practices. The Bureau is available to provide technical assistance to OMH and its facilities.

(2) The Centers of Excellence in Culturally Competent Mental Health Care at the Nathan Kline Institute and the New York State Psychiatric Institute have studied ways to make services more accessible and acceptable to New York State's cultural groups, developed provider and agency tools to enhance cultural competency, and developed new and innovative programs to enhance culturally competent integration of health and mental health services, language access, and engagement in care.

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APPENDIX A

Excerpted from: “Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals: Quality, Safety, and Equity (Joint Commission, 2010)”

TABLE 2. CHECKLIST TO IMPROVE EFFECTIVE COMMUNICATION, CULTURAL COMPETENCE, AND PATIENT- AND FAMILY-CENTERED CARE ACROSS THE CARE CONTINUUM

ADMISSION: CHAPTER 1

- Inform patients of their rights.
- Identify the patient’s preferred language for discussing health care.
- Identify whether the patient has a sensory or communication need.
- Determine whether the patient needs assistance completing admission forms.
- Collect patient race and ethnicity data in the medical record.
- Identify if the patient uses any assistive devices.
- Ask the patient if there are any additional needs that may affect his or her care.
- Communicate information about unique patient needs to the care team.

ASSESSMENT: CHAPTER 2

- Identify and address patient communication needs during assessment.
- Begin the patient–provider relationship with an introduction.
- Support the patient’s ability to understand and act on health information.
- Identify and address patient mobility needs during assessment.
- Identify patient cultural, religious, or spiritual beliefs or practices that influence care.
- Identify patient dietary needs or restrictions that affect care.
- Ask the patient to identify a support person.
- Communicate information about unique patient needs to the care team.

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TREATMENT: CHAPTER 3

- Address patient communication needs during treatment.
- Monitor changes in the patient’s communication status.
- Involve patients and families in the care process.
- Tailor the informed consent process to meet patient needs.
- Provide patient education that meets patient needs.
- Address patient mobility needs during treatment.
- Accommodate patient cultural, religious, or spiritual beliefs and practices.
- Monitor changes in dietary needs or restrictions that may impact the patient’s care.
- Ask the patient to choose a support person if one is not already identified.
- Communicate information about unique patient needs to the care team.

END-OF-LIFE CARE: CHAPTER 4

- Address patient communication needs during end-of-life care.
- Monitor changes in the patient’s communication status during end-of-life care.
- Involve the patient’s surrogate decision-maker and family in end-of-life care.
- Address patient mobility needs during end-of-life care.
- Identify patient cultural, religious, or spiritual beliefs and practices at the end of life.
- Make sure the patient has access to his or her chosen support person.

DISCHARGE AND TRANSFER: CHAPTER 5

- Address patient communication needs during discharge and transfer.
- Engage patients and families in discharge and transfer planning and instruction.
- Provide discharge instruction that meets patient needs
- Identify follow-up providers that can meet unique patient needs.

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ORGANIZATION READINESS LEADERSHIP: CHAPTER 6

- Demonstrate leadership and commitment to effective communication, cultural competence, and patient- and family-centered care.
- Integrate unique patient needs into new or existing hospital policies.

Data Collection and Use

- Conduct a baseline assessment of the hospital's efforts to meet unique patient needs.
- Use available population-level demographic data to help determine the needs of the surrounding community.
- Develop a system to collect patient-level race and ethnicity information.
- Develop a system to collect patient language information.
- Make sure the hospital has a process to collect additional patient-level information.

Workforce

- Target recruitment efforts to increase the pool of diverse and bilingual candidates.
- Ensure the competency of individuals providing language services.
- Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.
- Identify staff concerns or suggested improvements for providing care that meets unique patient needs.

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Provision of Care, Treatment, and Services

- Create an environment that is inclusive of all patients.
- Develop a system to provide language services.
- Address the communication needs of patients with sensory or communication impairments.
- Integrate health literacy strategies into patient discussions and materials.
- Incorporate cultural competence and patient- and family-centered care concepts into care delivery.

Patient, Family, and Community Engagement

- Collect feedback from patients, families, and the surrounding community.
- Share information with the surrounding community about the hospital's efforts to meet unique patient needs