Tool 4: How To Deliver the Re-Engineered Discharge to Diverse Populations

59. 1. Purpose of This Tool

The U.S. is made up of diverse multicultural populations.[1] Cross- cultural health care encounters involving a broad array of patients with diverse health beliefs, language preferences, cultural norms, and health-seeking behaviors occur everyday across the country. While many providers provide excellent cross-cultural care, language barriers and cultural diversity are still associated with worse care and preventable rehospitalization in many organizations.

The delivery of culturally and linguistically appropriate services is addressed throughout the Re-Engineered Discharge (RED) toolkit, but this tool specifically aims to:

Explain why it is important to address patients' cultural and linguistic needs as part of the RED.

Describe the infrastructure needed to deliver the RED in a culturally and linguistically competent manner.

Describe how discharge educators (DEs) can deliver the RED to patients with a diversity of language, culture, race, ethnicity, education, or health literacy.

Provide DEs with practical strategies to ensure the successful delivery of the RED to patients with cultural and language assistance needs, using effective cross-cultural communication and educational strategies.

This RED tool is meant to be used in concert with the other tools in the RED toolkit.

60. 2. Role of Culture, Language, and Health Literacy in Readmissions

Improving the discharge process for people who experience language barriers and cultural differences presents an important opportunity to promote patient-centered and family-centered care. It is a critical component of improving the quality of care and avoiding preventable readmissions.[2] See Case Example 1.

61. 2.1. Culture and Its Relationship to Readmissions

Culture is the learned, shared patterns of beliefs, values, attitudes, and behaviors characteristic of a society or population.[3] From this cultural context emerges the patient's health belief system and explanatory models of illness.[4] Patients' explanatory models for their health and well-being include their understanding of the causes, treatment options, and outcomes associated with their ailments.

In cross-cultural clinical encounters, multiple cultural influences and health belief systems come into play, such as the culture of the provider, the culture of the patient, and the culture of the health care system. When these cultures clash, misunderstandings about the nature of an illness, its remedies, and appropriate health behaviors are more likely to occur. Cross-cultural communication, which requires an exchange of shared meaning, can occur even when both parties speak the same language.[5]

Aside from the potential for deteriorating health or readmission as a result of the patient's not understanding the discharge plan, communication barriers can lead to a sense of not being understood as a person. This can lead to mistrust and treatment nonadherence, which can threaten the successful transition from hospital to home.[6] Thus, failing to address culture and language in the discharge planning process may expose patients to otherwise preventable adverse events and readmissions.

62. 2.2. Language and Its Relationship to Readmissions and Patient Safety

Limited English proficiency (LEP), the limited ability to speak English, can prevent people from interacting effectively with health care providers. More than 20 million people, or 8.6 percent of the U.S. population, have LEP.[7] People with LEP are 40 percent more likely to experience physical harm associated with an adverse event than English-speaking patients, and adverse events reported by LEP patients are more likely to be due to communication errors.[8] However, patients who used professional interpreters at the time of hospital admission had a shorter length of stay and were less likely to be readmitted to the hospital in the next 30 days than those who did not have professional language interpreters at admission.[9]

Without appropriate language assistance for LEP patients (i.e., interpretation and translation services), DEs will face challenges in teaching patients how to take care of themselves when they get home, including how to take their medicines. Arrangements for appropriate language assistance after discharge (e.g., postdischarge followup phone call, subsequent laboratory tests, followup appointments) are also needed.

63. 2.3. Health Literacy and Its Relationship to Readmissions

Health literacy refers to a patient's ability "to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[10] It is estimated that 77 million adults in the United States have limited health literacy and that health literacy barriers are more common among minority adults and those who did not speak English before going to school.[11]

Limited health literacy has been linked to more frequent hospitalization and readmissions.[12,13] The Joint Commission, in its report *What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety*, recommends practices to avoid miscommunication that could lead to readmission.[14] These practices are part of the RED and are described in detail in the following sections.

64. 3. Preparations for Providing the RED to Diverse Populations

As part of preparing to provide the RED to diverse populations, consult the *National Standards on Culturally and Linguistically Appropriate Services*,[15] a set of recommendations from the Department of Health and Human Services' Office of Minority Health. This section applies some of the standards to the implementation of the RED.

65. 3.1. Hiring Bilingual, Bicultural Discharge Educators

Staff who share the language and cultural background of the community a hospital serves help create a welcoming environment that facilitates clear communication.[16] If you have a concentration of LEP patients who prefer to use a particular language, consider hiring a DE who is bilingual and bicultural. If you hire a bilingual DE, you must ensure he or she is proficient in both languages.

If you expect bilingual DEs to interpret for other medical team members, you must make sure they are trained in medical interpreting and are qualified to fill that role. It can be tempting to try to "get by" with staff members who do not possess proficient language skills or by asking bilingual staff who do not have proper training to interpret. Professional development may be needed to avoid significant patient safety risks that can result from inadequate skills.

66. 3.2. Providing Cultural and Linguistic Competence Training

All DEs should participate in formal training in cross-cultural health care to gain a full appreciation of how culture and language influence health care. Even bicultural and bilingual DEs will be asked to provide services to patients with cultural and language preferences that differ from their own. DEs should strive to cultivate cultural self-awareness, avoid making assumptions about patients' needs, and be open to learning from patients themselves.[16]

Some free resources for cultural competence training include:

Effective Communication Tools for Healthcare Professionals (Health Resources and Services Administration [HRSA]), available at www.hrsa.gov/publichealth/healthliteracy/index.html.

Think Cultural (Office of Minority Health), available at https://www.thinkculturalhealth.hhs.gov.

The Provider's Guide to Quality and Culture (HRSA), available at http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English.

67.3.3. Ensuring Availability of Interpreter and Translation Services

All recipients of Federal funds, such as Medicare or Medicaid providers, must offer language assistance to any person requiring such services in a health care setting.[17] Language assistance includes the provision of both interpreter services (for oral communication) and translation services (for written communication). Access to language services facilitates patient participation in care. Investing in language services can help prevent costly readmissions and reduce the cost of providing high-quality health care.[18]

Qualified medical interpreters, defined in the text box below, should assist in all in-person and phone encounters with LEP patients. Even if a patient speaks English fluently, it may be necessary to employ interpreter services to help teach the discharge plan to supportive caregivers. Qualified translators are also needed to make written information available in the patient's preferred language.

Your hospital should have a language access plan that describes how patients' language assistance needs are identified and how they will be met. Resources that provide guidance in developing language assistance plans include *A Patient-Centered Guide to Implementing Language Access Services in Health Care Organizations*[19] and the *Speaking Together Toolkit*.[20]

68. 4. Overview of Delivering the RED to Diverse Patient Populations

Patients can benefit from a linguistically and culturally appropriate approach to implementing RED components. Some of the ways this can be done are listed in Table 1.

Table 1. RED Components and DE Responsibilities

RED Component	DE Responsibilities
1. Ascertain need for and obtain language assistance.	Find out about preferred languages for in-person oral communication, phone communication, and written materials. Determine patient's and caregivers' English proficiency. Arrange for language assistance as needed, including translation of written materials.
2. Make appointments for followup care (e.g., medical appointments, postdischarge tests/labs).	Inform providers of patient's language preference, language assistance needs, and cultural considerations. When possible, schedule patients with providers who have appropriate linguistic and cultural competence.
3. Plan the followup of results from tests or labs that are pending at discharge.	Alert person conveying results of the tests to patient of language preference, language assistance needs, and cultural considerations.

RED Component	DE Responsibilities
4. Organize postdischarge outpatient services and medical equipment.	Collaborate with case manager to ensure that instructions for durable medical equipment are in patient's and caregivers' preferred languages. Obtain interpreter services, if needed. Determine whether there are any cultural barriers to use of durable medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain them.	Obtain interpreter services, if needed. Ascertain what vitamins, herbal medicines, or other supplements patient takes and use of complementary and alternative medicine (CAM) therapies. Alert medical team to any possible drug-drug or drug-CAM interactions or harmful supplements. Assess patient's concerns about medication plan, especially conflicts with health beliefs. Confirm understanding through teach-back of what medicines are for, why it is important to take them, when and how to take them, and how much to take.
6. Reconcile the discharge plan with national guidelines.	Check whether modifications to national guidelines are appropriate for particular racial or ethnic groups.
7. Teach a written discharge plan the patient can understand.	Obtain interpreter services, if needed. Create an After Hospital Care Plan (AHCP) in the patient's preferred language as well as in English. Determine whether patient has any cultural concerns with the AHCP. Check that symbols and pictorial cues on AHCP medicine schedule are meaningful. Be respectful of the patient's culture and communicate an ethic of caring. Ensure that dietary advice is consistent with religious or cultural practices.

RED Component	DE Responsibilities
8. Educate the patient about his or her diagnosis and medicines.	Obtain interpreter services, if needed. Elicit patient's/family's explanatory model of the illness. Inquire about role of lay healers, faith healers, and CAM therapy use. Identify key family members and the patient's CAM healers to engage in explaining the diagnosis in a way the patient can understand and to support adherence to the AHCP. Document cultural considerations.
9. Review with the patient what to do if a problem arises.	Obtain interpreter services, if needed. Ensure that language assistance is available at the DE help line and the primary care provider after hours contact numbers and notify patient of that availability, if needed. Elicit beliefs as to what constitutes an emergency, reach an understanding, and instruct on what to do in cases of emergency.
10. Assess the degree of the patient's understanding of this plan.	Obtain interpreter services, if needed. Assess the degree of understanding by asking patients to explain in their own words the details of the plan. Contact family members and/or other caregivers who will share in the caregiving responsibilities, if needed. Identify mistrust of treatment plan that might result from conflicting patient beliefs/practices, and create plan to mitigate.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.	Include information about language preference, language assistance needs, use of CAM, and cultural considerations.
12. Provide telephone reinforcement of the discharge plan.	Obtain interpreter services, if needed. Probe as to whether there are any cultural or language barriers to following discharge plan.

Note: The rest of this tool addresses the DE directly.

69. 5. Getting Started With the RED for Diverse Populations

Strategies that assist health professionals to anticipate, identify, and address cultural and linguistic communication barriers can significantly improve the hospital discharge experience and reduce unnecessary readmissions. Your awareness of the potential for

cross-cultural communication barriers and use of strategies to anticipate and address these barriers can help avert mishaps. It is therefore essential for you to know how to assess communication and cultural needs and implement strategies to address barriers when providing the RED.

70.5.1. Assessing Communication Needs

To provide culturally and linguistically appropriate services, you first need to assess your patient's communication and cultural needs.

Inquire and document any specific patient needs for language assistance. This includes language preference for verbal and written communication and the need for interpreter and translation services. See the HRET disparities toolkit for guidance, available at www.hretdisparities.org/.[21]

Be sensitive to the fact that patients' language skills can diminish under stress. Patients who are usually proficient in English may find themselves needing language assistance. Also consider the language assistance needs of those who will help take care of the patient at home.

Conduct a thorough and respectful inquiry into the unique cultural patterns and values of patients. For example, check with the patient about dietary changes that may concern him or her, such as fasting or cultural food practices related to holidays or religious observances. This will allow you to tailor the discharge teaching to meet patients' needs and to ensure that patients' values and norms are integrated into the plan for care when the patient is at home.

Use materials and teaching methods (such as the teach-back method) that are appropriate for all levels of health literacy. This is a universal precautions approach and eliminates the need for health literacy screening.[22,23]

71.5.2. Using Nonverbal Communication Styles While Teaching the RED

While language is often the most commonly examined aspect of communication, nonverbal communication is a powerful and culturally rooted form of interaction. Nonverbal communication includes not only facial expressions and gestures, but also personal distance and time references. Here are some examples of how nonverbal communication can affect your conversation with patients.

Assertiveness: Differences in cultural norms regarding the appropriate degree of demonstrated assertiveness in communicating can create misunderstandings. For example, some racial or ethnic groups carry a legacy of discrimination in medical treatment. As such, they may present for care with the expectation of needing to advocate earnestly for the care they need and deserve. This can be expressed or perceived as aggression and create tension, resulting in undertreatment of pain, disregard of serious symptoms, or low patient confidence in providers and treatment plans.

Deference: Alternatively, some patients will not make eye contact with a provider as a sign of deference and respect toward the provider. However, this behavior can be misconstrued by providers as mistrust or dishonesty. In such a case, it is best to follow the patient's lead and not impose eye contact when it is not desired.

Agreeability: Finally, some patients always seem to agree, nod, and smile in response to everything you say. This can be due to a range of phenomena, including fear of the shame that could occur if the patient's lack of comprehension were revealed or simply the desire to please. Frequently, people mask their confusion. When this occurs, try the teach-back method to assess understanding and shared meaning.

72.5.3. Understanding Health Beliefs, Alternative Healers, and Attitudes About Medicines

People's sociocultural background influences their approach to health care and shapes their world view and values regarding health and illness.[6] Patients and their families and health professionals may not share the same health beliefs, such as what causes a disease or the benefits of traditional medicine. This diversity in health perspectives can heighten the risk of communication errors.

To ensure the success of a discharge plan, you should elicit the patient's understanding of his or her illness and explore how the individual wishes to address treatment. The Kleinman Questions in Table 2 have been used to integrate a cross-cultural perspective into clinical medicine.[6,24] These questions can be asked during your first meeting with the patient. You should practice them in simulation to get accustomed to cross-cultural inquiry.

Table 2. The Kleinman Questions

What do you think has caused your problem?
Why do you think it started when it did?
What do you think your sickness does to you? How does it work?
How severe is your sickness?
Will it have a short or long course?
What kind of treatment do you think you should receive?
What are the most important results you hope to receive from this treatment?
What are the chief problems your sickness has caused for you?
What do you fear most about your sickness?

Reassure your patient that his or her answers to these questions will help you in developing a comprehensive and effective treatment plan. If a treatment plan is not congruent with the patient and family's health beliefs, it is unlikely to be followed. In the discharge summary, you should inform the clinicians taking care of the patient about health beliefs and other cultural considerations.

You can encourage this discussion by asking such questions as:

“How do you prefer to treat your [condition, such as high blood pressure]?”

“Do you find it easy to take your prescribed medicines or do you prefer other kinds of treatment?”

“Is there anything that you’d be worried about if you took these medicines?”

“What do you think will help you get better?”

“Do you see anyone else who helps you with this problem?”

“Do you take any herbs or anything else to help you with this problem?”

73.5.4. Understanding Patients and Communicating Across Differences

Strive to overcome barriers to effective communication by approaching all patients with positive regard and an ethic of caring.[25,26] This can be done by being:

Attentive.

Honest.

Patient.

Respectful.

Compassionate.

Trustworthy.

In addition to the techniques listed in Tool 3, How To Deliver the RED at Your Hospital, the following are important:

Creating a relaxed atmosphere.

Repeating important messages.

Phrasing information and posing questions in different ways.

Accepting responsibility for a lack of understanding.

74. 6. Teaching the AHCP to Patients With Limited English Proficiency

Print the AHCP in the patient's preferred language, if possible. The RED Workstation can print the AHCP in English, Chinese, and Spanish. Provide the AHCP in the patient's preferred language, as well as in English for the benefit of health care providers and caregivers who read English. AHCPs that are not printed in the patient's preferred language should have a space in each section for a medical translator to write the translated discharge instructions in the patient's own language. Be sure that this is legible in the space provided.

Some tips for teaching the AHCP to patients with LEP are listed below:

Some cultural groups are reluctant to ask questions, which they see as challenging the authority of the health care provider. Emphasize that all patients have questions, you want to hear their questions, and you find questions reassuring rather than offensive.

Some patients are especially reluctant to reveal that they do not understand something, fearing that they will lose face. It is your responsibility to check that they do understand. Use the teach-back method to assess comprehension of discharge instructions, as described in Tool 3, How To Deliver the RED at Your Hospital.

Just like English-proficient patients, not all patients with LEP can read in their preferred language. Do not rely on the patient being able to read the AHCP. Make sure you have instructed the patient on all elements of the AHCP and confirmed that the patient understands.

The AHCP was designed to use symbols and color codes to help make the instructions understandable for patients with low health literacy or LEP. Be sure to explain the meaning of the symbols clearly and confirm shared meaning between you and the patient with respect to what the symbols indicate. For example, be sure to explain clearly that a sun symbol on the medication instruction sheet means to take the medicine in the morning or that a moon symbol means to take the medicine in the evening.

The AHCP includes a color-coded calendar to help patients learn how to take medicines and to help them remember the correct dates of their followup appointments. When printed using the Workstation, the calendar will offer to record major religious observances for a wide array of faiths. When helping patients arrange followup appointments, you can reference the calendar to determine whether any special religious observances will occur in the 30-day period following discharge. This information may be important when

scheduling followup appointments or to determine whether the occasion involves special foods or fasting that might require additional education or a change in the treatment plan.

75. 7. Using Qualified Medical Interpreters To Create and Teach the After Hospital Care Plan

If your patient speaks English less than proficiently and you are not a documented bilingual provider in your patient's preferred language, arrange for a qualified medical interpreter. It may be tempting to "get by" if your patient speaks some English or if you speak your patient's language well enough to have a conversation. "Getting by," however, can lead to medical errors. If an in-person interpreter is not immediately available and the need to talk with your patient is urgent, engage a telephone interpreter while you are waiting.

Do not use family or friends or others who are not qualified medical interpreters to interpret. Medical interpreting requires specialized skill and training. Further, patients have a legal right to determine whether they want family and friends to know their private medical information. Even if the patient prefers having a family member or friend interpret, also have a qualified medical interpreter present to correct any errors in interpretation. Never use a child under the age of 18 to interpret. Family members can be encouraged to support the patient and treatment plan rather than to serve as interpreters.

Familiarize yourself with the language assistance programs at your hospital. Learn the proper procedures for requesting language assistance and be aware if advance notice is needed. When arranging for language assistance for the final interaction when the AHCP is taught, be sure to inform the medical interpreter that up to 1 hour of assistance might be required. If you have little or no experience working with medical interpreters, find out what training is available to help you work more effectively and efficiently with interpreters.

76. 7. 1. Working With Qualified Medical Interpreters

A few tips for working with qualified medical interpreters are included here as an introduction. This is not a substitute for formal training on working with interpreters. More information about working with people with limited English proficiency is available in AHRQ's Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) training module, *Enhancing Safety for Patients With Limited English Proficiency*, available at www.ahrq.gov/teamsteppstools/.

Preparation. Before seeing the patient, brief the interpreter about the RED, what your role is, and what the goals are for the teaching session. Share relevant patient background information with the interpreter. Ask the interpreter what he or she needs from you during the meeting. Also ask the interpreter to inform you whenever he or she engages in conversation or diversions from the exact sentence by sentence interpretation with the patient. The interpreter may break role if the patient addresses him or her directly with a question

or statement or if the interpreter wants to make a suggestion to you as a cultural expert. Let the interpreter know that you expect him or her to alert you to any concerns about potential safety issues.

Etiquette. Address the patient, not the interpreter, and maintain eye contact with the patient. Try not to "think out loud" or have side conversations with the interpreter. This can cause patients to wonder about what is not being interpreted for them and can impair the rapport building process.

Dialogue. Talk slowly and clearly at a comfortable pace with pauses that allow for interpretation. Use plain language, not jargon. Confirm understanding and comprehension, asking the interpreter to give you the patient's exact words, not paraphrases, whenever possible. Make sure the interpreter is present for the entire conversation with the patient.

Debrief. After your session with the patient, ask the interpreter if he or she noticed anything pertaining to the patient that had not been expressed, such as subtle gestures or emotions.

Documentation. Document the presence of the qualified medical interpreter, the interpreter's name, and the name of the language service agency.

77.7.2. Accessing Interpreters by Phone and Video

Training in both the use of the language assistance devices and working effectively with a remote interpreter is essential. If you lack experience with language assistance devices, it is strongly recommended that you conduct a practice session before the initial patient meeting. For example, when using a telephone interpreter service, find out if there is a speakerphone or a dual handset so that both you and the patient have individual telephone handsets for use during your session. Practice connecting to the telephone and video interpreters and make sure the phone numbers, video links, and access codes are operational.

78.7.3. Handling Patient Refusal of Language Assistance

Occasionally, a patient with LEP will decline the assistance of an interpreter, believing that his or her English skills are sufficient, or will ask to use a friend or family member for interpretation. You should:

Make clear that interpreter services are provided free of charge.

Explain that it is the hospital's policy to provide interpreter services.

Obtain hospital interpreter services **even if the patient uses a friend or family member**. You should honor the patient's choice, but you also have the right to have a qualified medical interpreter present. Some hospitals have a "silent" interpreter present when friends

or family members interpret who speaks only to correct omissions or mistakes in interpretation. Having qualified medical interpreters present also helps protect the hospital from potential liability regarding miscommunication.[27,28]

79. 8. Understanding the Role of Family and Community

Family and community support is often essential to a patient's safe transition from hospital to home. In some cultures, the role of family members, and even members of the broader community (e.g., religious or spiritual leaders, traditional healers), is instrumental in the treatment of illness and medical decisionmaking. Neglecting to assess the presence and influence of family and community members before hospital discharge could lead to nonadherence to the discharge plan, dissatisfaction with the medical care received, and hospital readmission for relapse of symptoms or other adverse events following discharge. It is important, therefore, that you inquire and assess family and community involvement in a patient's care early in the hospital course.

The following are some ways cultural differences can influence your interactions with family and community members.

"Bad News." Issues of "truth telling" about serious diagnoses present dilemmas for patients, families, and medical team members. For example, there are cultural differences in beliefs about the power of hope and the negative consequences associated with losing hope. In certain cultural contexts, family members may object to disclosing a serious diagnosis to the patient. If the family advocates nondisclosure, fearing a decline in the patient's condition if informed about his or her condition, confer with the medical team on how to proceed.

"First-Line Responder." Some 90 percent of sickness episodes are managed exclusively within the circle of family and community lay healers.[4,6] Given that the family is often the "first-line responder" to a sickness at home, it especially important that they be advised on what to expect in the postdischarge period. Consider family members as more than potential personal caregivers in the home or transportation support for followup appointments, but also as lay healers and advisors to the ill patient.

Arbiters About Following Advice. Family or community leaders' or healers' concurrence with treatment recommendations at home may be essential to the patient's willingness to follow them. Find out from your patients whose judgments they rely on. If possible, obtain that person's agreement about seeking help, following treatment regimens, taking medicines, and attending appointments.

"Consultant Healer." Even when the patient is hospitalized, his or her family and spiritual or cultural healers may remain involved in treatment decisions. They often assess the quality of care, influence the patient's expression of symptoms, and shape the patient's understanding and expectations of the health care experience. Be respectful of these "consultant healers" and enlist their cooperation in postdischarge treatment.

Autonomy in Care and Decisionmaking at Home. In some cultures, family members play significant roles in care and decisionmaking for loved ones. While western norms emphasize personal autonomy, certain cultures have a more family-centered approach to decisionmaking and other cultures tend toward a more hierarchical kinship structure for decisions. Patient preferences must be balanced with standards of care regarding informed consent and confidentiality.

It is a good idea to ask the medical team if you have any concerns about the family or community members' role as you prepare the patient for discharge.

80. 9. Additional Considerations

You may ask questions to assess other culturally influenced factors that can relate to readmissions. These factors include dietary patterns, religious observance, gender preferences for caregivers, sexual orientation and gender identity, and mental health.

81. 9.1. Dietary Patterns

Conflicts with the dietary recommendations in the discharge plan can lead to setbacks in the transition from the hospital to home. You can ask the patient to review the dietary recommendations and assess whether the patient anticipates a problem adhering to the nutrition plan. If so, you can consult with the hospital dietitian to receive more information about how to assist the patient.

82. 9.2. Religious Observances

It is not uncommon for patients to adjust medication regimens and dietary patterns as part of religious observances. Such observances may include fasting or consuming special meals prepared for the occasion or may prohibit the use of certain treatments during periods of observance. Sometimes, these changes can jeopardize the success of the discharge plan. Try the following:

Use the AHCP calendar to identify common religious observances and ask the patient if there are religious observances not marked on the calendar that will be observed in the month following discharge.

Assess whether the patient's religious observance affects the discharge plan. If necessary, the medical team can be alerted to the potential problem and the discharge plan can be adjusted.

83. 9.3. Gender Preferences

For some patients, the gender of a provider is important to the delivery of health care. Gender preference may even extend to nonclinical staff, such as front office support and interpreters, who are engaged in collecting private health information. For example, female patients often prefer a female gynecologist. Indeed, in certain cultures, it is unacceptable for a male provider to treat a female patient.

When arranging for followup appointments, you should ask the patient if he or she has any preferences for a certain provider or whether gender is a concern. Attending to this cultural preference for health care will help increase the likelihood of successful continuity of care in the ambulatory setting and reduce the risk of readmission.

84.9.4. Sexual Orientation and Gender Identity

Many lesbian, gay, bisexual, and transgender (LGBT) individuals avoid or delay care because of perceived or real homophobia, biphobia, or transphobia. Create a nonjudgmental and secure environment so that LGBT patients feel comfortable. Be sensitive to your verbal and body language. Do not make assumptions about your patient's sexual orientation or gender identity, such as assuming that a same sex caregiver is or is not the patient's partner. Be sure that partners of LGBT patients are afforded the same regard and hospital privileges as spouses. Training on LGBT-specific skills can help you gain confidence in how to provide appropriate care to LGBT patients.

85.9.5. Mental Health

Mental health disorders, though common among hospitalized patients, are frequently undiagnosed and untreated and become important risk factors for rehospitalization.[29] There are several reasons for paying particular attention to the possibility of unmanaged mental health difficulties when working in a cross-cultural setting. These include populations who:

Have symptoms that are not recognized as diagnostic features of specific disorders because they have culturally mediated characteristics.[30,31]

Belong to cultures where psychiatric illness is highly stigmatized.

Do not realize that there are services that could help them because they come from societies where there are no mental health providers.

Have had trouble accessing mental health services due to language and cultural barriers.

Have been exposed to violence and trauma and are at heightened risk for posttraumatic stress disorder. A patient's trauma history is frequently not known by the physician.[32]

To start exploring the possibility of mental health symptoms, you might ask the following:

"It can be very stressful to be sick and to be in the hospital. How have you been holding up? How have you been dealing with your stress?"

You can also investigate specific circumstances that lead to mental health disorders. For example, when working with foreign-born patients, find out where they are from and when they left. It is quite useful to know some of the basic social and political history for your patient's country of origin.

Sources such as the CIA World Factbook are easy to use to learn information about countries and give you a sense of some of the challenges your patients may have faced.[33] To learn if your patient was likely to have been dislocated due to war, famine, or natural or political disaster, you might ask the following:

"What was happening when you left your country?

"Many people who left your country at that time were exposed to violence. Did that happen to you?"

Report any suspected mental health issues to the medical team for them to investigate and plan for treatment if needed.

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