How to Deliver the ReEngineered Discharge to Diverse Populations

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A note to users: We would greatly appreciate any feedback that you might have on how to improve this toolkit. This information should be directed to Project RED on Boston University's website, www.bu.edu/fammed/projectred/, and leave your comments or questions in the "contact us" section.

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1. The Purpose of This Tool

Culture, language and health literacy barriers can affect a patient's ability to engage in the discharge process and after-hospital self care that can lead to preventable hospital readmissions. The objectives of this tool are:

- To explain why it is important to address patients' culture and linguistic needs as part of the ReEngineered Discharge (RED).
- To describe the infrastructure needed to deliver RED in a culturally and linguistically competent manner.
- To describe how the Discharge Educators (DEs) can deliver the RED to diverse populations, defined as diversity of language, culture, race, ethnicity, educational background, health literacy and/or social circumstance.
- To provide DEs practical strategies to ensure the successful delivery of the RED to patients with socio-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 RED tools in this toolkit.

2. Culture, Language and Health Literacy Can Influence Readmissions

In its *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care*, the Joint Commission states that hospitals should incorporate the patient's unique needs into discharge planning and instruction.[1] Meeting patients' communication needs is critical not only to providing quality care, but also in avoiding preventable readmissions.

Case example: Undisclosed conflicts in health belief systems can affect a patient's ability to understand the discharge plan. For example, if a patient with asthma understands the illness to be a result of a poorly functioning immune system, it may be difficult for him to understand why treatment to quiet the immune system (i.e., systemic steroids) would help to make him feel better. If the DE identifies this problem as purely a health literacy barrier, he/she may simplify the discharge education approach with little improvement in patient understanding or acceptance of the treatment plan. However, eliciting and discussing the patient's explanatory model of his illness and his health belief system may alert the DE to the underlying cross-cultural conflict, allowing the DE to then notify the responsible clinician and suggest a culturally competent re-negotiation of the discharge plan to accommodate the patient's explanatory model of the illness.

2.1 Culture and Its Relationship to Readmissions

Demographic changes occurring across the United States are impacting and challenging the delivery of health care in U.S. hospitals. By 2030, racial/ethnic minority persons are expected to represent 40 percent of the US population while the health care workforce is expected to be predominantly represented by non-Hispanic whites.[2] One consequence of this rapidly changing demographic is that there will be a notable increase in the prevalence of cross-cultural clinical encounters involving a broad array of patients with diverse health beliefs, language preferences, cultural norms, and health seeking behaviors.

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 model of the illness.[4] A patient's explanatory model for his/her disease includes his/her understanding of the cause, the treatment options and outcomes associated with the disease. In cross-cultural clinical encounters, there are multiple cultural influences and health belief systems in action, such as the culture of the provider, the culture of the patient, the culture of Western medicine, and the culture of the healthcare system. When these cultures clash, misunderstandings about the nature of an illness, its remedies, and appropriate health behaviors are more likely to occur. It is important to remember that cross-cultural communication requires not just translation of *words from one language to another*, but also an exchange of shared meanings.[5]

Aside from the obvious consequence of not understanding the discharge plan (i.e., non-adherence with follow-up appointments, medicines, etc), communication barriers can lead to a sense of not being understood as a person on the part of the patient and the clinician, leading to mistrust and treatment non-adherence that threaten the successful transition from hospital to home.[6] Thus, omitting pertinent cultural and linguistic considerations from the discharge planning process may inadvertently expose patients to otherwise preventable adverse events that can lead to unplanned readmissions.

2.2 Language and Its Relationship to Readmissions

Limited English proficiency (LEP) – the limited ability or inability to speak, read, write or understand the English language – can prevent individuals from interacting effectively with health care providers. Over 20 million people or 8.6% of the US population are LEP status.[7] LEP status has been associated with communication problems. For example, non-English speaking patients in the U.S. are 40 percent more likely to experience physical harm associated with an adverse event than English-speaking patients reporting an adverse event, and adverse events reported by LEP patients are more likely to be due to communication errors.[8] Without appropriate language assistance for LEP patients, DEs will face challenges in teaching patients how to take care of themselves when they get home, including how to take the medicines that could prevent readmission. Arrangements for appropriate language assistance after discharge (e.g., post-discharge follow-up phone call, subsequent laboratory tests, at follow-up appointments) are also needed, and required by law. For more information please see The Office of Minority Health's explanation of Culturally and Linguistically Appropriate Services (CLAS) at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

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."[9] It is estimated that 77 million US adults 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.[10] Yet, assessing health literacy in a cross-cultural context can be complex, with a wide array of cultural factors potentially affecting a patient's ability to understand health-related information. 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.[11] These practices are part of RED and are described in detail in the following sections.

3. Preparing to Provide RED to Diverse Populations

3.1 Hiring bilingual, bicultural Discharge Educators

Staff who share the language and cultural background of the community served by a hospital help create a welcoming environment that encourages open communication.[1] If you have a concentration of LEP or non-English speaking 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/she is proficient in the secondary language and has training in medical interpreting. It can be tempting to try to "get by" with staff members who possess less than proficient language skills or by using bilingual staff who do not have proper training in medical interpretation but doing so can pose a significant patient safety risk and should be avoided.

3.2 Cultural and Linguistic Competence Training

All DE's should participate in formal training in cross-cultural healthcare to gain a full appreciation of how culture and language influence healthcare. Even bicultural and bilingual DEs will be asked to provide services to patients with cultural and language preferences that differ from their own. DE's should strive to cultivate cultural self-awareness, avoid making assumptions about patients' needs and be open to learning from patients themselves.[1] In addition, all DE's should receive training in cross-cultural communication and the "Culturally and Linguistically Appropriate Services" (CLAS) standards.[12]

Some available resources for cultural competence training include:

- Unified Health Communications (HRSA): http://www.hrsa.gov/publichealth/healthliteracy/index.html
- Think Cultural (OMH): https://www.thinkculturalhealth.hhs.gov
- Addressing Language and Culture in Health Care Practices http://www.vimeo.com/15822032
- The Provider's Guide to Quality and Culture (HRSA): http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

3.3 Availability of Interpreter and Translation Services

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 healthcare.[13] A trained medical interpreter should assist in all in-person and phone clinical encounters with patients requiring language services. Even if your patient speaks English fluently, it may be necessary to employ interpreter services to help teach the discharge plan to supportive caregivers.

What is a qualified medical interpreter? A qualified medical interpreter must have language proficiency, medical knowledge, and interpreter skills. Several organizations have developed standards for interpreter certification including the National Council on Interpreting in Health Care (www.ncihc.org), the National Board of Certification for Medical Interpreters (www.certifiedmedicalinterpreters.org) and the American Translators Association (www.atanet.org).

4. Overview for Delivering RED to Diverse Patient Populations

Each of the components of the RED program can benefit from a culturally-appropriate approach. Some of the ways this can be done are listed in the Table.

RED Component	RED Culturally-Responsive Approach
1. Make appointments for follow-up medical appointments and post discharge tests/labs.	• Arrange for language assistance if needed at follow up appointments. • Discuss reason for and importance of appointments, including tests/laboratory work. • Instruct patient in any preparation required for future tests. • Inquire about follow up with traditional healers. • Discuss whether any upcoming religious or holiday observances will interfere with follow up appointments. • Confirm patient understanding of timing and location of appointments and any advance preparation required through teach-back.
2. Plan for the follow-up of results from lab tests or studies that are pending at discharge.	• Review laboratory tests that have been performed but results are not ready. • Determine how results of the tests will be conveyed to patient.
3. Organize post-discharge outpatient services and medical equipment.	• Collaborate with case manager to ensure that durable medical equipment is obtained and how and when it will be delivered to the patients home • Teach how to use durable medical equipment, with language assistance if needed.
4. Identify the correct medicines and a plan for the patient to obtain and take them.	• Ascertain what vitamins, herbal medicines, or other dietary supplements patient takes and use of complementary and alternative medicine (CAM) therapies. • Alert clinicians to any possible drug-drug or drug-CAM interactions or harmful supplements. • Explain what medicines to take, emphasizing any changes in the regimen, using color-coded calendar in AHCP with symbols and pictorial cues. • Confirm understanding through teach-back. • Assess patient's concerns about medication plan, especially conflicts with health beliefs.
5. Reconcile the discharge plan with national guidelines.	• Compare treatment plan with National Guidelines Clearinghouse recommendations for patient's diagnosis and alert the medical team of discrepancies.
6. Teach a written discharge plan the patient can understand.	• Create an After Hospital Care Plan (AHCP) in the patient's preferred language. • Review and orients the patient to all aspect of the AHCP. • Employ the color-coded calendar with symbols and pictorial cues to support comprehension and mastery of discharge plan.
7. Educate the patient about his/her diagnosis.	• Obtain interpreter services, if needed. • Identify key family members and community leaders or healers to engage in explaining the diagnosis in a way the patient can understand.

RED Component	RED Culturally-Responsive Approach
	• Clarify role of family members. • Elicit patient's/family's explanatory model of the illness. • Inquire about role of lay healers, faith healers and CAM therapy use. • Document cultural considerations.
8. Assess the degree of the patient's understanding of this plan.	• Obtain interpreter service, if needed. • Assesses the degree of understanding by asking patients to explain in their own words the details of the plan. • Might require removal of language and literacy barriers. • Might require utilizing qualified interpreters. • Might require contacting family members and/or other caregivers who will share in the care-giving responsibilities. • Identify mistrust of treatment plan that might result from conflicting patient beliefs/practices, and create plan to mitigate.
9. Review with the patient what to do if a problem arises.	• Obtain interpreter service, if needed. • Instruct on a specific plan of how to contact the PCP by providing contact numbers for evenings and weekends. • Instruct on what constitutes an emergency and what to do in cases of emergency.
10. Expedite transmission of the discharge summary to clinicians accepting care of the patient.	• Deliver discharge summary and AHCP to clinicians (physicians, visiting nurses, etc.) via fax or email within 24 hours of discharge. • Include information about language preference, language assistance needs, and cultural considerations.
11. Provide telephone reinforcement of the Discharge Plan.	• Call the patient within 3 days after discharge to reinforce the discharge plan and help with problem-solving. Use qualified interpreters if caller does not speak patient's preferred language. • Staff DE Help Line. Answer phone calls from patients, family, and/or other caregivers with questions about the AHCP, hospitalization, and follow-up plan in order to help patient transition from hospital care to outpatient care setting. Use qualified interpreters if DE does not speak patient's preferred language.

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. The DE's awareness of the potential for a cross-cultural communication barriers and use of strategies to anticipate and address these barriers can help avert mishaps. It is therefore essential for the DE to know how to assess communication and cultural needs and implement strategies to address barriers when providing the RED program to patients who would benefit for this assistance.

5.1 Understanding Patients and Communicating Across Differences

All patients and clinicians have sociocultural backgrounds that influence their approach to health care and shape their worldviews and values on health and illness. This diversity in health perspectives brings both challenges and opportunities to clinical care. Among the challenges relevant to cross-cultural health care are the heightened risk for communication problems and discordance in health belief systems between patients, their families and clinicians. A number of approaches to cross-cultural communication have been developed.

Below is a summary of three approaches to cross-cultural communication.

5.1.1 The Kleinman Model

The Kleinman Questions to elicit health beliefs[14]

The Kleinman Model
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?

5.1.2 The LEARN Model

The LEARN Model (Listening, Explanation of provider perceptions, Acknowledgement of differences, treatment Recommendations, and Negotiation of plans:[15]

The LEARN Model

The LEARN Model by Berlin and Fowkes is a structured approach to cross-cultural communication based on a mnemonic of LEARN.

L	Listen to the patient's perspective
E	Explain and share one's own perspective
A	Acknowledge differences and similarities between these two perspectives
R	Recommend a treatment plan
N	Negotiate a mutually agreed-on treatment plan

5.1.3 The RESPECT Model

The RESPECT Model (Respect; Explanatory model; Social context, including Stressors, Supports, Strengths and Spirituality; Power; Empathy; Concerns; Trust/ Therapeutic alliance/ Team).[16]

5.2 Non-Verbal Communication Styles While Teaching the RED

While language is often the most commonly held notion of communication, one culturally-rooted aspect of communication style is the emphasis on non-verbal communication.

Non-verbal communication includes not only facial expressions and gestures; it also involves personal distance and time references. Here are some examples of how non-verbal communication can affect patient-clinician interactions.

- Assertiveness: Differences in cultural norms regarding the appropriate degree of demonstrated assertiveness or deference in communicating can create misunderstandings during clinical encounters. For example, some racial/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 deserve and need. This can be expressed or perceived as aggression and create tension between clinicians and patients, resulting in under-treatment of pain, disregard of serious symptoms or low patient confidence in providers and treatment plans.

- Deference: Alternately, some patients will not make eye contact with a clinician as a sign of deference and respect toward the provider. However, this behavior can be misconstrued by clinicians 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.

- Agreeable: Finally, some patient always seem to agree, nod and smile in response to everything you say. Yet, there is some question as to whether they truly agree or understand the treatment plan. When this occurs, try the teach-back method to assess understanding and shared meaning.

The rest of this tool addresses the DE directly.

5.3 Health Beliefs, Alternative Healers and Attitudes About Medicines

Illness is a culturally constructed experience molded by an individual's health belief system, settled within a complex social, family and cultural context. How a person copes and behaves in relation to illness is based on his/her culturally-defined explanatory model and meaning of the illness.[6] It is therefore not uncommon to find as many explanations for an illness as there are diverse cultures residing in a community.

To ensure the success of a discharge plan, you should elicit the patient's understanding of his/her illness and explore how the individual wishes to address treatment. To gather this information, you might ask

"What do you think has caused your illness?"

"What do you think will help you get better?"

Reassure the patient that their answers to these questions will help you in developing a comprehensive and effective treatment plan. This approach will allow you to identify any possible underlying discordance between the patient, the family and the clinical team pertaining to how the disease process is defined and beliefs about the proper course of treatment. You should inform the primary clinician regarding patient disagreement. You can encourage this discussion by asking:

"How do you prefer to treat your 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 the medication also?"

"Would you consider using both garlic and the medication?"

You should check with the patient about dietary changes that may concern him/her, such as fasting or cultural food practices related to holidays or religious observances. Be sure the patient understands when a diet is needed to avoid specific disease complications such as for avoiding Coumadin (anticoagulant) toxicity which is sensitive to diet, or such conditions as glucose control among diabetics or salt intake to prevent worsening of congestive heart failure.

Techniques that can be used to encourage communication include:

- Listening carefully to what is said
- Repeating messages that are not readily understood
- Accepting responsibility for a lack of understanding
- Phrasing questions in different ways
- Creating a relaxed atmosphere.

Strive to overcome barriers to effective communication by approaching all patients from different cultural backgrounds with positive regard and an ethic of caring.[17] This means focusing on the responsibility to the patient and demonstrating attributes of:

- Attentiveness
- Honesty
- Patience
- Respect
- Compassion
- Trustworthiness

5.4 Assessing Communication and Cultural Needs

To assess the success of the RED program among diverse populations, some strategies include:

- Conduct a thorough and respectful inquiry into the unique cultural preferences and values of patients. 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.
- Inquire and document any specific patient needs for language assistance. Please see the HRET Disparities Toolkit for guidance: http://www.hretdisparities.org/ [18]
- 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. Moreover, patients who competently speak more than one language may have a clear language preference.
- 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 circumvents the need for health literacy screening.

6. Teaching the AHCP to Limited English Proficiency Patients

Using the RED workstation, the After Hospital Care Plan (AHCP) can now be printed in English, Chinese Mandarin and Spanish. Some tips for teaching the AHCP for LEP patients are listed below:

- Use a "universal precautions" approach for discharge education, assuming that all patients have some limitation in health literacy. Even patients who have adequate health literacy when they are healthy may have difficulty understanding health information when they do not feel well or worried.

- Use the teach-back method to assess comprehension of discharge instructions that is described in the RED tool called "*How to Deliver the RED at Your Hospital*".

- Remember that just like English-proficient patients, not all LEP patients 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 the patient understands. Provide the AHCP in English as well the patient's preferred language, for the benefit of health care providers and care takers who read English.

- AHCPs that are not printed in the patient's preferred language have a space in each section for a medical interpreter to print the translated discharge instructions in the patient's own language. Be sure that the printing is legible in the space provided.

- 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, not at noontime or that a moon symbol means to take the medicine in the evening, not at bedtime.

- The AHCP includes a color-coded calendar to help patients learn how to take medicines and to help them remember to the correct dates of their follow-up appointment. When printed using the workstation, the calendar will record major religious observances for a wide array of faiths. When helping patients arrange follow up 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 follow up appointments or to determine whether the occasion involves special foods or fasting that might require additional education or a change in the treatment plan.

7. Using Medical Language Assistance to Create and Teach the AHCP

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.[19] Qualified medical interpreters can improve the quality of health care services for LEP patients. 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.

Familiarize yourself with the language assistance programs at your hospital. Learn the proper procedures for requesting language assistance and be aware if advanced 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 one hour of assistance might be required. Common options for trained medical interpreter services are:

- Face-to-face trained medical interpreter at bedside
- Trained medical interpreter accessed by phone or video

It is not appropriate to engage the patient's family or friends as medical interpreters to deliver the RED program. They may not be able to capably interpret medical information and/or it may interact with power relations within the family in unpredictable ways. Family involvement can be encouraged to support the patient and treatment plan rather than to serve as interpreters.

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 training on working with interpreters.

- **Preparation**: Before seeing the patient, explain to the interpreter what the RED is, what your role is and the goals of the teaching session are. Share relevant patient background information with the interpreter. Ask the interpreter what he/she needs from you during the meeting, and ask them to inform you whenever he/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 them directly with a question or statement or if the trained medical interpreter wishes to make a suggestion to you as a cultural expert.
- **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.
- **The Dialogue**: Talk slowly and clearly at a comfortable pace with pauses that allow for interpretation. Avoid using jargon. Confirm understanding and comprehension, asking the interpreter to give you the patient's exact words, not paraphrases, whenever possible. If the patient uses a

Trained Medical Interpreter Tip
Direct your empathy and response in English toward the patient. Remember to always look toward the patient when you are speaking, not toward the trained medical interpreter. The trained medical interpreter will provide the verbal translation of your words. However, the nonverbal communication can still be provided by you.

colloquial term, ask the trained medical interpreter to clarify its meaning if possible, and the patient's intended meaning when using it. Make sure the interpreter is present for the entire conversation with the patient.

- **Debriefing:** After your session with the patient, ask the trained medical interpreter if they noticed anything pertaining to the patient, such as subtle gestures or emotions.

- **Confidentiality and Accuracy**: Do not use informal interpreters or family or friends as interpreters. 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 competent medical interpreter present to correct any errors in interpretation. Never use a child under the age of 18 to interpret.

- **Documentation**: Document the presence of the trained medical interpreter, the interpreter's name and language service agency name.

7.2 Trained Medical Interpreter Accessed by Phone and Video

DE training in both use of the language assistance devices and working effectively with an interpreter are essential. If you are not experienced with using language assistance devices, it is strongly recommended to conduct a practice session before the initial patient meeting. For example, when using a telephone trained medical interpreter service, find out if there is a dual handset such that both you and the patient have individual telephone handsets for use during your session. If not, a speaker phone system is needed. Practice connecting to the telephone to access the trained medical interpreter service and make sure the phone numbers and PIN codes are operational.

7.3 What if the Patient Declines Language Assistance

Occasionally, a patient with limited English proficiency will decline the assistance of an interpreter, believing that their English skills are sufficient, or request to use a friend or family member for interpretation. The hospital's policy should be able to provide interpreter services to all patients whose preferred language is not English. 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 of interpreters, but you also have the right to have an interpreter of your choice. Having both interpreters present also helps protect the hospital from potential liability regarding miscommunication. Hospitals have paid millions for failure to use competent interpreters.[20, 21]

8. The Family as Caregivers after Hospital Discharge

Family support is often essential to a patient's safe transition from hospital to home. Yet, the role of family members in the treatment of illness and medical decision making varies considerably across cultures. It is important, therefore, that you inquire and assesses family involvement in a patient's care early in the hospital course. Some ways in which the cultural differences across families can influence hospital discharge encounters are:

- Giving "Bad News": Issues of "truth-telling" about serious diagnoses present dilemmas for patients, families and the clinical team. For example, in certain cultural contexts, family members may object to disclosure of health information to the patient himself/herself In such situations, the patient's family and clinicians could disagree about the disclosure of a serious diagnosis to the patient; with the family fearing a decline in the patient's condition if informed about his/her condition.

- "Consultant Healer": The role family members commonly play is as consultant healers. Some ninety percent of sickness episodes are managed exclusively within the circle of family and community lay healers.[4,6] Even when hospitalized, a patient's family and spiritual or cultural healers may remain involved in treatment decisions, assessing the quality of the care, governing the patient's expression of symptoms and shaping the patient's understanding and expectations of the healthcare experience.

- "First Line Responder": Given that the family is often the "first-line responder" to a sickness at home, it should be expected that they will be instrumental in post-discharge medical care and decision making for a patient. You should consider family members as more than potential personal caregivers in the home or transportation support for follow up appointments, but also as lay healers and advisors to the ill patient. Neglecting to assess the presence and influence of family members before hospital discharge could lead to untoward consequences of non-adherence to the discharge plan, dissatisfaction with the medical care received, and hospital readmission for relapse of symptoms or other similar adverse events following discharge.

Disclosure of Bad News

The disclosure of bad news such as a terminal diagnosis is a commonly encountered cross-cultural issue in health care. The healthcare system in the United States and other Western countries places great emphasis on the autonomy of the patient. The Patient Self-Determination Act secures this right legally for all patients in the United States, but its relevance to patients of various cultural backgrounds has often been debated.

- Arbiters about Following Advice: Family or other caregivers may be essential to the patient's willingness to follow treatment recommendations at home, including the decision about when to seek help, what treatment regimens to follow and the willingness or ability to take medicines and attend appointments. Family involvement could be particularly important for vulnerable populations who traditionally may have found the healthcare system difficult to access and unreceptive to their concerns.

- Autonomy in Care and Decision-Making at Home: In some cultures, family members play significant roles in care and decision making for loved ones. The desire for autonomy can be quite different from western values. In essence, certain cultures have a more family-centered approach to decision making, as compared to cultures with a greater focus on the individual as decision

maker. Patient preferences must be taken in balance with informed consent and confidentiality standards of care.

- Other cultural factors that are relevant at the time of hospital discharge can include:
    - Differences in beliefs about the power of hope and the negative consequences associated with losing hope
    - The role of the physician and paternalism
    - The way social roles change with aging

It's a good idea to ask the medical team if they have any concerns like these as you prepare the patient for discharge.

9. Additional Considerations

You may ask questions to assess for other culturally-influenced factors that can potentially be related to readmissions. These factors include dietary patterns, religious observances and gender preferences of care givers.

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 recommendation materials and assess whether the patient anticipates a problem adhering to the diet. If so, you can consult with the hospital dietician to receive more information about how to assist the patient.

Cultural competency tip

Make sure the diet plan is culturally relevant and includes foods that the patient is accustomed to eating at home.

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. Some tips include

- You can use the AHCP calendar to identify common religious observances and should also ask the patient if there are religious observances not marked on the calendar that will be observed in the month following discharge.
- You can then assess whether the patient's religious observance affects the discharge plan. If necessary, the clinical team can be alerted to the potential problem and the discharge plan can be adjusted.

9.3 Gender Preferences

For some patients, the gender of a clinician is important to the delivery of healthcare. Gender preference may even extend to non-clinical 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 clinician to treat a female patient. (Keep in mind that this request is based on the patient's preferences and values not a judgment of the clinician's competence.)

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

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