

IMPROVING CULTURAL COMPETENCY *in Children's Health Care*

Expanding Perspectives



On any given day American doctors' offices, hospital emergency rooms, and health centers, are alive with the sounds not only of Spanish, but also of Haitian, Creole, Somali, Hmong, Mandarin, Russian, and other languages from across the globe. These languages communicate more than words. They can also reflect experiences, cultures, and belief systems that may not fit neatly into the expectations of the U.S. healthcare system.

This divide, not only in language, but also in culture, belief, and knowledge, contributes to health care disparities in the United States. As the Institute of Medicine noted, "evidence of racial and ethnic disparities in health care is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services." The National Initiative for Children's Healthcare Quality (NICHQ), with its mission of eliminating the gap between what is and what can be in health care for **all** children, is committed to taking action to eliminate disparities.

The increasing diversity of American society is especially evident among our youth. By the year 2020, more than one in five children in the United States are expected to be Latino, one in six children will be Black, and one in 16 Asian. Diversity in culture and beliefs is not restricted to those whose skin color differs from their healthcare providers or those speaking different languages. Cultural differences can also exist because of differences in perspectives about the role of faith and the use of alternative and complementary medicine and healers.

The challenge before us is how best to create a healthcare system in which all children receive care that is safe, effective, efficient, timely and family centered, regardless of background or cultural

differences. What practical changes in processes can make healthcare providers and the systems in which they work more effective in responding to the needs of diverse children? And how can health care delivery organizations track their progress? This report describes our initial efforts to answer these questions, and provides recommendations and findings from early pilot test results.

This project has struck a deep and responsive chord both in the practice community and among those experts on the topic of cultural competency. We are truly grateful to the expert and advisory panel members who have given generously of their time and knowledge and to our pilot sites who have shared their experiences, advice, and stories. We are also, of course, grateful to The California Endowment for their generous support of this effort.

This report, and this project, marks one step in our efforts to address disparities in children's health care and to advance the ability of organizations to provide culturally competent care. We will integrate our findings from this project into all of our future work in improving the quality of health care for all children in this country. We hope that you will do the same, and I welcome your continued participation in this important work.



Charles J. Homer, MD, MPH
President and CEO, NICHQ
July 2005



Taking a look at the big picture.

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Expanding Perspectives

Beyond the Clinical Environment



A story—this one real—can illustrate the importance of providing culturally competent care better than recitation of statistics:

A distraught mother brought her four-year-old son into the pediatric outpatient clinic of a large, urban hospital. The boy had an angry-looking wound between the first and second fingers of his right hand. The family was Hmong, refugees from Laos, and while the mother understood some English, her speaking ability was limited. Haltingly, she told the doctor that four days ago, the boy had been playing with a knife and had cut himself. This was their first visit to the doctor.

Examining the boy, the doctor determined that the tendon had been severed and that infection had set in. She called in a hand specialist colleague, and together they concluded that, because of the time that had elapsed from the injury, surgery would be necessary within 36 hours to prevent permanent loss of function in the boy's hand. By this time, an on-call interpreter had arrived to explain the situation to the boy's mother.

As soon as the mother understood from the interpreter that there was to be surgery, she grabbed her son and shouted that there could be no operation. The interpreter tried to explain how serious the situation was, and that the surgery would be necessary for the boy to be able to use his hand, but the mother still refused. The doctors, becoming frustrated, called in a social worker and a nurse to try to help convince the mother to schedule the surgery for the next day. Using the interpreter, they spoke to the mother, urging her to reconsider for the well-being of her son, but to no avail. The situation deteriorated, with each side inflexibly holding to its position. The mother eventually took her son and stormed out of the clinic in tears. The doctors began to talk about calling in the state child protective services agency to obtain a court order declaring the mother neglectful and forcing her to consent to the surgery.

This story, while extreme in its specifics, reflects the widespread experience for families with diverse backgrounds and different beliefs from those in the mainstream medical culture. Like children

who are poor, minority, or who come from other countries and cultures, children who come from non-English-speaking families generally experience worse health care and worse outcomes than more affluent, white, English-speaking children. For non-English-speaking children and families, the sporadic availability of interpreters (who, unlike the interpreter in this story, are often untrained or are family members), exacerbates the problem. This situation, even with the intervention of a trained interpreter, had the potential to result in one of two equally devastating scenarios: either permanent medical damage to the child, or—if a court order were involved—an explosive confrontation between two cultures, that could lead to the child being pulled from his family and the destruction of the hospital's ongoing relationship with the local immigrant community. Indeed, the well-known book, *The Spirit Catches You and You Fall Down*, tells a tragic story of another Hmong child in which each of the scenarios above plays out. (For the full citation of this book, see the reference section.)

Fortunately, neither of these dire outcomes occurred. This situation was in fact resolved in a way that demonstrates the potential of the healthcare system to provide accurate diagnosis and effective treatment while respecting the beliefs, customs, and languages of patients: culturally competent care.*

The interpreter in this case was actually more than just an interpreter; she was one of two “interpreter/cultural mediators” hired by the hospital. Her job was to not only communicate words, but also to interpret cultural beliefs and foster mutual understanding between physicians and their patients. In this role, this interpreter visited the mother later that same day to find out the reasons for her strong reaction to the surgery. She found out that when the boy had first cut himself, four days prior, the mother had taken him to the Hmong community's shaman (healer). The

* The American Academy of Pediatrics uses the phrase “culturally effective care”.

shaman had performed several rituals and told the mother that under no circumstances should the wound be further touched or tampered with until it had healed. This warning was the reason for the mother's panic at the thought of surgery.

The interpreter consulted with the local Hmong community leader. Together, they arranged a meeting with the shaman, the mother, and the doctors. Through the interpreter, the doctors explained once again the need for the surgery. In the presence of the shaman and the respected community leader, the mother remained calm. After hearing what the doctors had said, the shaman turned to the mother and said in Hmong, "I see that these doctors are also shamans of their community. In that case, and because of the severity of the injury, our rules do not apply. It is permitted for them to touch your son, and heal him with their surgery." With the shaman's permission and blessing, the mother agreed immediately. The surgery was performed that same day and the boy ultimately recovered.

In this case, several strategies were used to bring two cultures together in a way that resulted in the appropriate health care for the boy. The clinic used staff trained in providing culturally competent care to elicit and understand the perspectives, beliefs, and fears of the parent; an interpreter/cultural mediator was used to improve the family's access to appropriate health care; and in recognition of cultural values, the family and a community leader were included in joint decisionmaking.

We don't know how common, or how rare, this type of culturally competent care really is. We do know that evidence of healthcare disparities in this country continues to mount. In 2002, the Institute of Medicine released a review of the published literature, concluding that the "evidence of racial and ethnic disparities in health care is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services."¹ Such disparities have been found in preventive care (e.g., immunization rates), in care of children with chronic conditions (e.g., use of appropriate medications for children with asthma), and in acute care settings (e.g., use of pain medication for children with trauma). Communication problems

are pervasive; minority parents of young children more often report that providers never or only sometimes understood their child-rearing preferences; Latino parents report more often than parents of other groups that providers never or only sometimes understood their child's needs.²

We also know that when care is provided in a way that is culturally competent, it is both safer and more effective. In one study, those clinical sites that emphasize and train their staff to be more culturally competent have patients who were more likely to take appropriate medication for their asthma.³

The importance of providing culturally competent care is clear. The question is how can we take the current system of care and move it in the right direction? Numerous organizations have developed policies and standards for healthcare organizations in this arena. The most prominent of these are the Cultural and Linguistically Appropriate Services [CLAS] standards developed by the DHHS Office of Minority Health. While helpful, such standards may have little impact on practice and care unless accompanied by more specific strategies and tools that can be used to implement the standards and improve care, and by measures that track whether progress is being made.

NICHQ, the National Initiative for Children's Healthcare Quality, is dedicated to eliminating the gap between what is and what can be in health care for all children. We have tackled numerous clinical topics, such as the care of children with asthma, attention deficit hyperactivity disorder (ADHD), and cystic fibrosis in order to improve care and to move care closer to guidelines and other recommended approaches. The frameworks, strategies, and tools we have used in that work seemed to us absolutely applicable to making care more culturally competent, and so, with the support of The California Endowment, we undertook this work.

No longer can we divide our nation into those who receive quality health care and those who do not.



Methods

Given the wide spectrum of ideas about what constitutes culturally competent health services, and the broad policy focus of much prior work in this field, this initiative sought to be practical. We wanted to develop practical strategies that healthcare organizations—primary care practices in particular—could use in order to become better able to care for diverse populations. In addition, the project's intent was to develop measures that could be used to track progress towards the goal of culturally competent care.

The approach we used to undertake this work was similar to the one we use in developing improvement strategies for children with specific health conditions. As described below in more detail, this method combines academic literature review with a formal expert process to elicit opinions of authorities in the field concerning “best practices.” We then undertook pilot testing to assess the feasibility of the recommended strategies and measures.

Building on Existing Resources

The first step in developing the practical strategies was to draft a charter that laid out the rationale for the project. Our charter stated the current understanding of the problem, including factors such as lack of culturally competent care, disparities in child health care, changing demographics, poverty, and access. This background was followed by a statement of our mission and the goals we wanted to attain. Finally, we included our method for achieving these goals and how we would disseminate the information gained from this project.

In developing this project, we built on a solid foundation of research and the work of several other organizations. We began by compiling a bibliography of publications focusing on identification and measurement of cultural competency and disparities in the delivery of health care, as well as those addressing the health needs of the children whose health care is compromised by lack of cultural proficiency in primary care settings. We used many of the same search words initially used in the *Setting the Agenda for Research on Cultural Competence in Health Care: Final Report*.⁴ (This is the final, comprehensive report for the Cultural Competence Research Agenda project, sponsored by the U.S. Department of Health and Human Services Office of Minority Health (OMH) and Agency for Healthcare Research and Quality (AHRQ) to examine how cultural competence affects healthcare delivery and health outcomes.) Using Medline and a general website search, pediatric-specific terms were also included together with the key

search words noted above. We then reviewed the compiled bibliographies for additional publications.

We created abstracts, compiled the relevant literature, and consulted national experts (see advisory panel, below), and national organizations that were addressing cultural competency.

Advisory Panel

Concurrent with the literature review, we identified an advisory panel that included representatives from organizations that have major impact on the delivery of health care for children, as well as organizations that had undertaken substantial activities in this field. The advisory panel served several functions throughout the project. They helped identify the members of the expert panel, kept the project team informed of other major initiatives in the field, provided input into our materials, and communicated information about this initiative and its products to their organizations.

Expert Panel

We identified 20 experts who were selected based on their academic or practical expertise in the area of cultural competency, particularly in children's health care. The experts were convened for a two-day meeting. These experts reviewed the charter and a draft copy of a set of changes or strategies that had been recommended to achieve improvements (often called “change concepts.”) The experts were asked to integrate the change concepts with the components of the Care Model for Child Health, a modification of the work of Ed Wagner, MD, and his colleagues at Improving Chronic Illness Care at Group Health of Puget Sound.

The Care Model for Child Health is designed to improve the outcomes of health care of children through integration of a prepared, proactive management team, an informed, actively engaged patient and family, and a supportive and connected community. We have found this framework to be a powerful tool in implementing change at the practice level in many NICHQ projects.

Using the Care Model as a framework, we developed strategies for change in each of its six components in order to achieve culturally competent care:

- **Community Resources**
- **Health Systems**
- **Family and Self-Management Support**
- **Delivery System Design**
- **Decision Support**
- **Clinical Information Systems**

The expert panel developed many specific strategies, and then condensed and consolidated these strategies through the use of formal group process techniques. NICHQ staff subsequently reviewed and refined these recommendations with additional input from both the expert and advisory panels. Finally, the list of change concepts was prioritized by the project team and the project chair, so that providers could identify where they might concentrate first.

Pilot Testing

When the draft change package was finalized, we began pilot testing. The purpose of the pilot testing was to gain understanding of the feasibility and usefulness of the proposed strategies and measures. Sites were recruited to participate in the pilot testing through the California State Medi-Cal program, through contacts with other national organizations, and through personal contacts of advisory and expert panel members.

We undertook two different types of pilot testing. In the first type, participating providers were asked to incorporate one or more of the strategies into their clinic sites or to test measures and report on their feasibility. We gathered information about these efforts through both surveys and interviews.

In a second pilot process, we simply asked providers to evaluate the entire list of strategies and measures on an assessment scale. They were asked to then indicate whether or not they had implemented any of these strategies or measures and to summarize the results of their efforts.

Key Resources

Key resources that we identified included the National Standards for Culturally and Linguistically Appropriate Services (CLAS), developed in 2001 by the Office of Minority Health of the Department of Health and Human Services; the Organizational Cultural Competence Assessment Profile developed in 2002 for the Health Resources and Services Administration by the Lewin Group, Inc; and the Chronic Care Model (on which we based our Care Model for Child Health), developed by Ed Wagner, MD, director of Improving Chronic Illness Care, a program of the Robert Wood Johnson Foundation.

- **The CLAS Standards**, according to the Office of Minority Health, “are proposed as one means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups. However, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.”⁶

The 14 standards, (listed on page 34), are divided into those that are mandates (required for all recipients of Federal funds); guidelines (for Federal, State and national accrediting agencies); and recommendations (suggested for voluntary adoption by health care organizations).

- **The Organizational Cultural Competence Assessment Profile**, prepared for HRSA, was prompted by the question, “How do we know cultural competency when we see it?” This report enables an organization to assess its level of cultural competence in seven domains, or focus areas: organizational values, governance, planning and monitoring/evaluation, communication, staff development, organizational infrastructure, and services/interventions. In developing the Change Package for the NICHQ Project, we used these domains as a jumping off point to develop both strategies and evaluation measures that health care providers can use to promote cultural competency.

Conceptual Framework: Care Model for Child Health

Ed Wagner and his colleagues at Group Health Cooperative analyzed hundreds of studies relating to the care of the chronically ill to determine the characteristics of successful programs. From these data, they developed the Chronic Care Model, which has been endorsed by the Institute of Medicine's report, *Crossing the Quality Chasm*. NICHQ has made modest modifications to this model to make it more consistent with children's health care. The result is the Care Model for Child Health that has been used in many of NICHQ's improvement programs.

Healthcare System and Organization

The care children receive in individual practice settings is strongly affected by the environmental context and the practice's organizational setting and policies.

Community Resources

The lives and well-being of children and families are tightly intertwined with their communities. Day care, Head Start, schools, and after-school programs are just some of the essential community resources that must be integrated with health care to address the needs of children.

Family and Self-Management Support

Although physicians prescribe treatment, patients decide whether to follow these recommendations. Family and self-management support focuses on the need for the healthcare system to support and enable the ability of children and families to manage their own care. This includes emphasizing the family's role in managing their child's well-being and illness and providing support to the child so s/he is able to manage his/her care in a developmentally appropriate way. Ultimately, collaborating with families in setting shared goals for child and family well-being and providing educational materials and resources to support them in reaching their goals is at the heart of this component.

Delivery System Design

Preventive care, care for children with chronic conditions, and care for children with special healthcare needs is most effectively delivered by a multidisciplinary team with clear understanding of roles and how each contributes to a child's care. Team members should all have sufficient training for their roles and should communicate often. Care should be delivered in planned encounters rather than in purely reactive, acute visits. Encounters may be in person, but can also use alternative approaches, such as group visits and non-visit care such as phone or email.

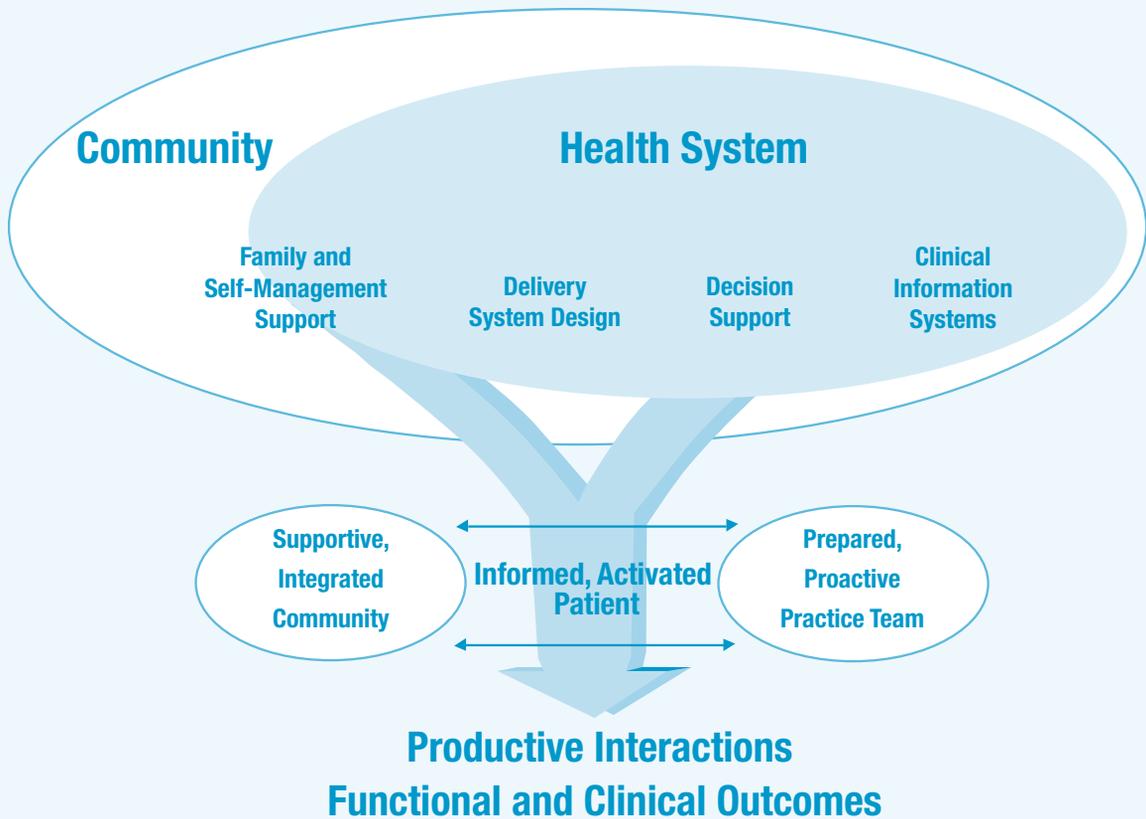
Decision Support

Practices should embrace evidence-based guidelines where they are available. These guidelines should be embedded in documentation systems such as charts and electronic medical records to minimize reliance on individual recollection. Primary care practitioners should have access to specialty expertise, either through referral or specialty consultation and supervision.

Clinical Information Systems

Information technology can be used to identify entire populations of children with specific needs, assess practice performance, target high-risk populations, and plan for future needs.

Care Model for Child Health



“Cultural competence seems to be evolving from a marginal to a mainstream healthcare policy issue and as a potential strategy to improve quality and address disparities.”

*Cultural Competence and Health Care Disparities:
Key Perspectives and Trends*

Health Affairs volume 24, Number 2 March/April 2005

Joseph R. Betancourt MD, et al.

The Cultural Competency Change Package

A typical Change Package is a set of materials and ideas that guide and enable teams who are participating in a Collaborative* to achieve breakthrough change in their settings. Change Packages generally have three elements: a conceptual framework—in this case the Care Model for Child Health—that describes features of the ideal system for the topic; a set of changes or strategies that have proven to be effective in achieving improvements (often called “change concepts”); and a set of measures that enable Collaborative teams to track progress toward their goals.

For Improving Cultural Competency in Children’s Health Care, we used our expert panel to help us create a Change Package of what we believe are the most promising practices for achieving culturally competent care. It became clear to us early in this process that the scope of this issue was too big to address in one Change Package. We see this version as the very best initial approach to improving care: the first layer.

Summary of Key Findings from Pilot Testing

In our pilot testing, we sought to identify the obstacles and challenges faced by organizations implementing different components of the change package, and some of their strategies for getting around these challenges. These obstacles are highlighted for each component and are followed by examples of successful, real-life strategies.

The pilot testing phase also underscored that organizational size was often an important predictor of the challenges faced and strategies used to address them. As a result, where applicable, we have highlighted the issues and strategies that are pertinent to small or solo practice and those relevant for larger organizations, group practices, or community health centers.

How to Use This Change Package

From the beginning it was our intent to use what we learned in this process to inform all other NICHQ work. So, from our pilot testing, literature review, and many conversations with experts in the field, we came up with a short list of specific change concepts and measures that we will include in all future NICHQ Change Packages. You will find these items highlighted in the following pages. We do not want to imply that the items on the short list are more important than the others. We do, however, feel that when used together these are the best way for an organization—large or small—to get started towards improving care for all patients in a culturally and linguistically sensitive way.

* For information on the Breakthrough Series™ Collaborative, please visit the Institute for Healthcare Improvement website, www.IHI.org.

Community Resources

Goal: Partnerships to meet the needs of families and children

Change Concepts

Potential Strategies

1. Create and sustain meaningful partnerships with key community leaders and representatives to enhance and inform communication between providers, staff, patients, and families and to identify specific community strengths and needs.

- Assess and update information about community demographics, languages, and epidemiology.
- Encourage and retain participation of community members on organizational governing bodies and advisory committees.
- Establish and maintain forums for meeting with community leaders to identify key community concerns.
- Have community leaders serve as liaisons between providers/staff and community members.
- Meet with community leaders and organizations to improve access and promote preventive care.
- Encourage families to participate in community programs that are effective at improving health and mental health outcomes (e.g., physical activity programs).

2. Involve community in planning, implementing, and evaluating services and policies.

- Include community members in process for developing, implementing, and evaluating education and resource materials.
- Identify community representative(s) to engage in quality improvement and patient safety programs (e.g., preventive services).
- Organize focus groups, including community leaders, to aid in planning service changes including those related to the CLAS standards.
- Address identified barriers to community participation in planning, implementing, and evaluating provided services (e.g., childcare, funding, etc.).
- Assess and address community reported barriers and facilitators to care at all levels both quantitatively and qualitatively.
- Establish and utilize relationships with diverse race/ethnic/language news sources to promote preventive screening and positive health behaviors.

“Quality improvement efforts within health systems that serve children of color would reduce disparities in health care, which are essentially disparities in quality.”

Anne C. Beal, MD, MPH

Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care
Health Affairs Volume 23, Number 5 Sept./Oct. 2004

Obstacles and Challenges

The pilot study revealed key differences between small private practices on the one hand and larger institutions and community health centers on the other in terms of staffing and resources. Small private practices and solo practices found it difficult to invest staff time in developing community relationships. “Time spent away from my patients cuts into my income,” said one practitioner. In contrast, larger organizations were able to distribute the efforts associated with these strategies among a larger number of staff.

Successful Strategies

For solo or small practices solutions that were time and resource efficient included having staff and providers make community connections through their personal activities, such as attending church and participating in community organizations. These connections were used to identify sources for ethnic-specific information and materials that could be used as office resources. In addition, some offices reported advertising job openings in small, ethnic-specific newspapers in order to increase the diversity of the office workforce.

Larger organizations are able to distribute the tasks necessary for building community relationships among different departments. For example, Human Resources departments advertised jobs in ethnic-specific media and public relations staff also worked with these media organizations to disseminate information about preventive care and other services. Some organizations reported sending staff and providers to participate in meetings at community centers, schools or other local programs to share and gain knowledge and to build relationships.

One institution created a video called “How to Utilize the Healthcare System.” It was translated into several languages and widely distributed to community organizations, health departments,

local clinics, and other sites. Some segments were even aired on the local Somali television station. It contained information such as how to make appointments and when and how to use the emergency department.

Large organizations also found focus groups and surveys to be useful tools for gathering data on the issues—such as lack of transportation—that are barriers to health care for specific populations. These focus groups were conducted in neighborhoods with large number of residents from a specific racial or ethnic group. Providing child care and refreshments were found to encourage participation in the focus groups.

Effective community outreach was found to improve health and lead to reciprocal relationships. One pilot site reported encouraging community organizations to present at a clinic/hospital health fair or event and encouraged participation by reserving enrollment in certain health programs for individuals and families from that organization.

To learn more about the racial/ethnic groups, large organizations reported asking patients to act as experts and share their experiences and beliefs about health care with staff and providers. Other organizations reported using the local health department to gather population data for catchment areas or to help connect patients to activities and resources in the community. Others asked community support or service organizations to share materials and information that would be useful to the patient populations being served.

Case Study

“Care in the Context of Community”

Children’s Hospitals and Clinics of Minnesota is an urban health system with one hospital in Minneapolis and one in St. Paul. The large outpatient pediatric clinic in the Minneapolis hospital serves a diverse patient population. Half of the patients are from minority groups and one quarter have limited English proficiency. When Boris Kalanj, the director of cross-cultural care and interpreter services, came to work at the hospital four years ago, he detected a problem: “We had staff interpreters for Spanish and Hmong languages, but they were not too happy because they felt their role was defined too narrowly,” he says. “They described feeling like ‘voice-boxes’ whose job it was to translate only words. This meant we were ignoring the complexity of conveying the full meaning between different languages or the cultural context in which the communication occurred. We were, in effect, de-contextualizing the essential communication in the process of giving and receiving care.”

As a result, the hospital expanded the role of its interpreters to “interpreter/cultural resources.” These staff members were asked to interpret meaning-for-meaning, rather than word-for-word, picking up on cues for implicit cultural content and the potential for culturally-based miscommunication. “In each situation their task is to assess the urgency and centrality of the issue, and then intervene by sharing cultural information they see as relevant and likely to help improve patient care,” explains Mr. Kalanj, a social worker with expertise in the effects of psychological trauma. “In order to do this, they must interpret cultural models that are expressed by the patient as well as the caregiver.”

Going still further with the support of a one-year startup grant, the hospital added two new positions called “interpreter/cultural mediators” to its staff. These new positions combined the roles of interpreter, cultural competency educator, and community

health worker. In addition to participating in individual clinical visits, these staff members teach a curriculum for limited English proficient patients to help them understand and make use of the healthcare system, and they teach hospital staff about cultural attributes as they relate to care. Their efforts are supported by the full-time educator, whose job is to train staff throughout the organization on various aspects of clinical cultural competency.

Additionally, the hospital has put into place several of the community strategies suggested in the NICHQ Change Package. “We try to create a welcoming environment for newcomers, including several thousand Hmong refugees who came from Thailand in 2004,” says Mr. Kalanj. One innovative project, co-organized with community partners, was a series of mass health screenings for the newlyarrived refugees. “Normally these exams are done individually for each family member, with low rates of completion. We organized them in the format of a ‘village health fair,’ held in one of the area hospitals. A great number of individuals and families completed their health screening during the day and at the same time had a chance to visit numerous health promotion and community resources booths.” His department collaborates on production of patient education materials, including information sheets, booklets, and videotapes. These are distributed at health fairs in the community, through local media and community centers, and at clinics serving diverse immigrant populations.

To promote community partnerships, hospital staff are assigned to collaborate with community organizations, including the Minnesota Department of Health, the Asian Pacific Association, and the Somali-American Friendship Association. These contacts have helped identify several important community leaders. The hospital then organized a series of luncheon meetings with the leaders. “These meetings allowed

for formal exchanges of information and good will,” said Mr. Kalanj. They were also a useful way to gather information from leaders about major healthcare issues and barriers to care in their respective communities. “In order to be effective,” said Mr. Kalanj, “we have to make this kind of contact actively and continuously.”

Another way of connecting with the community is to involve ethnic healers in bridging cultural gaps in service, said Mr. Kalanj, “We have at times called upon local Muslim imams and Hmong shamans to help with patient communication and negotiate treatment and follow-up care. In the future, we plan to formalize these relationships on an on-call basis and reimburse these healers for their time.”

As there is always room for improvement, Mr. Kalanj would like to see the inclusion of racial and ethnic data in the hospital’s ongoing quality improvement measures, including safety reports. He would also like a more systematic way to implement health literacy assessments at the time of intake or admission, tracking, for example, not only which languages are spoken in the home, but also which languages are read in the home.

The issues described above are magnified in states such as California and New York

where large populations, 40 and 28% respectively, speak a language other than English at home (ref: Census 2000), and the numbers of different languages spoken and cultures represented are vast. In these states, some organizations prioritize their efforts by identifying threshold groups to focus their efforts. Threshold groups are defined as those populations speaking a particular language (other than English) who meet a numeric threshold of 3000 (reference for definition: <http://www.hhs.gov/ocr/lep/guide.html>). In addition, California has several laws that place additional requirements for written translation of materials on any agency that receives state funding. Threshold guidelines can be useful in guiding the extent and depth of services available. For example, if 20% of families receiving care are Spanish speaking, a large organization will likely want to consider having on-site interpreters or bilingual staff interpreters as well as a range of translated patient education materials. However, when a family presents for care speaking a language that is less common in the community, organizations may find it more appropriate to use contract interpreters or telephone interpreters.



Healthcare System and Organization

Goal: Create an environment and mechanisms that promote high quality care

Change Concepts

Potential Strategies

1. Assess organizational and individual understanding of culturally and linguistically effective care and implement appropriate strategies for making and sustaining improvements.

- Cultural competence is part of job descriptions.
- Use a standardized tool for annual organizational assessment of cultural competency (including signs, materials, trainings, staff diversity, etc).
- Collect, analyze, and report patient population data by race, ethnicity, and language.
- Analyze all quality and patient safety indicators by race, ethnicity, and language to identify areas of disparities in care.
- Integrate cultural competency related measures into internal audits, performance improvement, and error reduction programs. (e.g., use of interpreters).
- Use varied methods (e.g. online, self-paced, in-person training) to educate providers and staff about culturally competent care, and evaluate the training outcomes.
- Educate providers and staff about how to elicit and document families' cultural beliefs and practices.
- Identify bi- and multi-lingual staff and train them to be interpreters.
- Train providers in the use of trained and untrained interpreters.
- Provide training in CLAS standards, Limited English Proficiency (LEP) guidelines, Title VI, and general culturally competent care strategies to all staff and providers.
- Include information about culturally proficient care in employee orientation programs.

2. Demonstrate organizational and leadership commitment and support for culturally and linguistically effective care.

- Educate organizational leaders about why culturally competent care is essential to high quality care.
- Adopt written policies and procedures that support culturally and linguistically competent care.
- State organizational intent with regards to cultural competency in strategic plan and policy and mission statements.
- Have organizational leaders develop/review, revise, and recommit to organization's mission in the area of culturally effective care; develop specific goals to support mission.
- Establish a budget line and a reporting system within the institution for all cultural competency related activities including interpreter services and staff/provider training.

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Demonstrate organizational and leadership commitment and support for culturally and linguistically effective care.

- Integrate cultural competency into all discussions of patient care and operations at staff meetings, presentations, and other core activities.
- Business and service decisions should consider identified disparities and understanding of the population served.
- Remain transparent when dealing with any errors and barriers to quality care in areas where disparities have been identified.
- Implement a system (that includes dedicated staff time) to recruit, retain, and promote minority staff who are reflective of the patient population served.
- Designate staff responsible for overseeing implementation of activities to promote acceptance, understanding, and enthusiasm for all aspects of culturally proficient care.
- Provide grievance process information that is available in the preferred languages of the patient population served.
- Provide incentives to encourage improvement of quality of care for all patients.
- Integrate cultural competency related measures into patient satisfaction assessments.
- Include cultural competency related issue on new patient/intake forms. (e.g., use of complimentary and alternative medicine, traditional healers).
- Increase allotted visit time for patients requiring interpreters.
- Reflects by organizational setting the patient population served through artwork, color scheme, and multi-lingual signage.

▶ **3. Provide linguistically effective care at all points of contact.**

- Provide and adequately fund interpreter services.
- Implement a system to link bi- or multi-lingual staff with LEP patients.
- Visibly and accessibly provide information about patients' right to receive language assistance in multi-lingual signage throughout the system.
- Visibly and accessibly list local options for interpretation (e.g., telephone interpreters, in person interpreters, etc.).
- Identify cultural/linguistic barriers to care in order to help patients navigate the healthcare system.
- Identify pertinent demographic information that will assure referral settings are knowledgeable of specific patient needs (e.g., preferred language, need for interpreter).
- Use a "navigator" program for new immigrants.

Obstacles and Challenges

Providers working in small or solo practices reported having to “muddle through” when caring for patients who spoke a language that was not spoken by a staff member. One provider reported feeling that at times it was better not to have an interpreter, “With an interpreter we might get the whole laundry list of patient complaints, which we don’t have the resources to meet and for which we will not be reimbursed,” a perception clearly not conducive to good care! While such perceptions may be widespread among those in smaller practices, two recent reports—one from the Commonwealth Fund and the other from the California Academy of Family Physicians—list specific strategies that can be used to help smaller or solo practices provide effective language services such as free web-based resources for translated health education materials, brief tips for helping untrained bilingual staff serve as interpreters, and specific recommendations about what equipment to purchase to improve telephone interpretation. (Please see the Resource section at the end of this publication for links.)

Some obstacles and challenges were raised by providers in all types of organizations, regardless of size. The most prominent of these is the issue of money. Some organizations may balk at the obvious cost of using interpreter services, either on staff or as contractors. These obvious costs may be outweighed by the hidden costs in quality and risk resulting from using untrained, bilingual staff or worse, family members. An intermediate option may be the use of telephonic interpreter services, which can cost \$1.50 per minute, although again the visible cost of this was cited as a barrier by some.

Another issue raised by many in different types of organizations is the challenge of incorporating cultural competency in job descriptions. One widely used approach organizations reported is the use of “preferred” or “required” as descriptors for desired language skills when posting job requirements.

Successful Strategies

In small or solo practices, creating a more culturally competent practice sometimes necessitates a less formal approach. In one small office, staff members from different cultural backgrounds teach each other about specific beliefs and customs within their respective communities. At another site, the medical director encourages impromptu, informal conversations among supervisors and staff—in the break room or over

lunch—about respect for patients even when disagreeing with the way that the families are managing their child’s care. The medical director found this approach to be useful with staff although less effective with peers.

Several smaller offices also reported using bilingual staff as interpreters. Although not as effective as using professionally trained interpreters, and potentially interfering with job performance in the staff member’s main area of function, for smaller organizations it is often the only viable option for providing access for patients with language barriers. The informality of many smaller organizations enables areas of contribution to that organization in one area (interpreting) to balance job performance (e.g., number of laboratory tests performed) in another. To improve their interpretation skills, bilingual staff can benefit from undergoing interpreter training. The California Academy of Family Physicians guide, “Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members,” suggests strategies for smaller or solo practices to train bilingual staff to function as interpreters. (Please see the Resource section at the end of this publication for links.)

Larger organizations can spread the responsibilities of implementing strategies for improving culturally competent care across many different departments. For example, Human Resources departments track the number of staff who receive training in cultural competency or skills for working with healthcare interpreters. One pilot testing organization reported requiring staff to take biannual tests on a variety of topics relevant to patient care and safety, as well as cultural competency. The results of these efforts are tracked in an online system.

A few larger organizations had constituted committees to assure institution-wide efforts to promote cultural competency. These committees—whose membership typically came from many departments across the institution—addressed cultural competency goals such as ensuring a diverse workforce that reflects the communities served and providing a mandatory training program in cultural competency and health disparities for all staff. Other organizations opt to integrate cultural competence efforts into existing committees, such as quality assurance or patient relations. Thus, the QA committee could look at quality data according to race/ethnicity or the patient’s primary language to identify disparities and opportunities to improve processes of care. A committee focused on patient relations could look at the patient

satisfaction data to identify any differences among cultural or linguistic groups in order to improve.

Feedback from the Health Plan of San Mateo

The Health Plan of San Mateo (HPSM) participated in pilot testing some of the strategies specific to this component of the care model. With an interest in understanding the need and benefits of providing telephonic interpreter services for its members, HPSM used the pilot project as a way to move this agenda forward. They identified two primary goals:

1. Assess organizational and individual understanding of culturally and linguistically effective care and implement appropriate strategies for making and sustaining improvements, and
2. Provide linguistically effective care at all points of contact.

Using a process that included a baseline assessment of provider interest, clinical need, and technology capabilities and a baseline assessment of the number of limited English proficiency (LEP) patients and interpreter need, HPSM began the pilot in two practices, one family practice and one pediatric practice. After training staff and providers in the use of Language Line Interpreting Services and how to effectively communicate with an interpreter, HPSM had seven (four in one and three in the other) Language Line Telephones installed in the two clinics.

HPSM paid for all costs associated with this pilot, so the two practices were not burdened. Although this

was a huge plus, the short timeline we gave for pilot testing did affect the number of sites they were able to recruit for the pilot.

Although HPSM had some initial problems with the technology, the phone lines were ultimately installed correctly and Language Line has been available to providers in the two clinics. Within a very short time period, they have had some successes. (See the story “We Speak Your Language” page 21) Despite the diversity of languages spoken in the region, the predominant language used has been Spanish. The cost is approximately \$1.50 per minute. In the first two months, they used 144 minutes of Language Line time for a cost of \$338. The ultimate direct costs, and the costs saved, will only be apparent after a longer period of use.



We Speak Your Language!

Health Plan of San Mateo members can receive free interpreter services. Please tear the form and give it to your doctor so he/she can help you in your language. HPSM does not encourage the use of family members and friends as interpreters.

Spanish

¡Hablamos su idioma!
Los miembros del Health Plan of San Mateo pueden recibir servicios de intérprete gratuitos. Por favor arranque la forma y désela a su doctor/a para que el/ella le pueda ayudar en su idioma. HPSM no recomienda el uso de familiares o amigos como intérpretes.

Chinese

我們會說你的語言！
HEALTH PLAN OF SAN MATEO 提供免費翻譯服務給我們的會員。請撕開此表格，並交給你的醫生來安排此項服務。HEALTH PLAN OF SAN MATEO 不鼓勵由你的家人或朋友來幫忙翻譯。

Tagalog

Kami ay nagsasalita ng inyong wika!
Ang mga miyembro ng Health Plan of San Mateo ay makakakuha ng walang bayad na interpreter service. Pilasin ang form na ito at ibigay sa inyong doktor para matulungan kayo sa inyong wika. Ang paggamit ng isang kapamilya o kaibigan bilang interpreter ay hindi iminumungkahi ng HPSM.

Russian

Мы говорим на вашем родном языке!
Участникам программы Health Plan of San Mateo (HPSM) полагаются бесплатные услуги переводчиков. Просьба оторвать этот корешок и передать его своему лечащему врачу, с тем чтобы он или она могли организовать оказание вам помощи на вашем родном языке. HPSM не поощряет привлечение родственников и знакомых в качестве переводчиков.

تحدث لغتك!
بإمكان المشاركين في برنامج الصحة بمقاطعة سان ماتييو Health Plan of San Mateo الحصول على خدمات الترجمة مجاناً. الرجاء أن تقص الاستمارة وتسلمها إلى طبيبك حتى يتمكن الطبيب من مساعدتك في لغتك. لا تشجعك برنامج الصحة بمقاطعة سان ماتييو على استخدام أفراد عائلتك وأصدقائك كمترجمين.

Time to re-order cultural & linguistic forms! Please call HPSM's Health Educator at (650) 616-2170.



Poster created by HPSM for use in their pilot sites

Case Study

“We Speak Your Language

The Health Plan of San Mateo (HPSM) is a county-organized health system located in the San Francisco Bay Area that provides health services to members throughout San Mateo County. Ravenswood Neighborhood Health Clinic in the south and PediaHealth Clinic in northern San Mateo each provide services to HPSM members. From the outside, these clinics look quite different, but they do share in common language diversity among their patients. Ravenswood serves many patients who speak Spanish, Samoan, or Tongan. PediaHealth patients are primarily Filipino, Latino, Burmese, and Chinese. While some staff in each clinic are bilingual in English and Spanish, few or none speak the other languages of their patient populations.

“Both clinics have the need for interpreter services,” said Wayne Pan, MD, PhD, Medical Director of HPSM. “So we were extremely pleased when NICHQ asked us to be part of the cultural competency pilot testing. We were particularly interested in putting into place and testing the effectiveness of the telephonic interpreter services program, Language Line, in order to provide linguistically appropriate services to more of our patients.” Language Line offers 24-hour-a-day interpreter services for providers and patients via three-way telephone hookups. Each person uses a headset as they communicate simultaneously with the Language Line interpreter.

Even before being approached by NICHQ, HPSM had been putting cultural competency programs in place. “We had already begun a work group to provide more cultural and linguistic training to both the clinical and the administrative staff,” said Dr. Pan. “We were also testing several of the suggested strategies and measures, including documenting the percent of patients receiving care in their preferred language; the training outcomes of culturally appropriate care, including the use of interpreters; use of a system to link multilingual staff with limited English

proficiency patients; and visibly providing easily accessible information for patients about their rights to receive assistance in multiple languages.”

The medical directors of PediaHealth and Ravenswood expressed interest in the telephone interpreter pilot project, so Dr. Pan and HPSM’s Health Educator, Liliana Ramirez, arranged for staff trainings and the acquisition of the dual headset telephones.

When asked about barriers, Dr. Pan identified the perception of many providers that interpretation services are unnecessary as many families bring friends or relatives to appointments to act as interpreters. “Most of our patients, as well as many staff, have been accustomed to using family members as interpreters during clinical visits,” says Dr. Pan. “This is clearly not a good idea, since family members can misinterpret medical information or withhold information from both patient and doctor.” Also, using family or friends as interpreters may inaccurately label the family as being proficient in English, when in fact they are not. To accurately document a family’s ability and their language preference, HPSM has developed stickers to be placed on each chart. Staff members record each patient’s language preference and whether an interpreter was requested or used.

Another barrier is technological. “It is important to work with a technical staff member before ordering the Language Line phones,” said Dr. Pan, “just to be sure that the right equipment— analog or digital, for example— is ordered and that it will work with the clinic’s existing phone system.” A third potential barrier is financial. “The Language Line service can be expensive, and we need to ensure that it is being used appropriately for patients in our health plan, and only for the purposes for which it is intended,” he said.

(continued on next page)

Although these barriers exist, a success story occurred quickly once the lines were in place. Ravenswood medical director, Larry Bruguera, MD, FAAFP shared that many of their Tongan patients come to the center only when their health interferes with their jobs. Even in acute situations, patients can be reluctant to seek care, especially if there are language barriers. Dr. Bruguera described a 67-year-old Tongan man who had been having problems with incontinence for several years. Due to embarrassment, as well as logistical problems, this patient stopped going to his follow-up appointments with the urologist. “When his problem became severe enough, he did finally come in to see us,” said Dr. Bruguera. “We checked his old records and found an early diagnosis of prostate cancer. Apparently, the family member who had been accompanying him to visits (and interpreting for him) never told him this, so he did not understand the need for follow-up care.”

This situation was resolved through the use of the Language Line. “As soon as the Language Line was in place, I used it to communicate the diagnosis of prostate cancer to this patient,” said Dr. Bruguera. “I can’t help but feel that language difficulties and a cultural family reticence had contributed to his lack of knowledge about his condition until that day. When he was directly and clearly advised of his diagnosis through the Language Line, however, he became much more engaged, both with me and with the process of his care.”

The healthcare relationship became much more productive after that. “The patient no longer had to go through the protective filter of family members in order to communicate with his doctors,” said Dr. Bruguera. “The Language Line is helping to ensure that patient, family members, and medical staff can now work together to make sure he receives the care he needs for his cancer.”

Although this first success story is of an adult patient, the implications of Language Line use for pediatric patients are great. Through improved communication, parents and clinicians will now better understand each other and the potential for care negotiation will be much stronger.

Heartened by the NICHQ project, Dr. Pan says, “We have seen ten years of studies documenting healthcare disparities, yet no one has really addressed what to do about it in a systematic way,” he said. “This pilot project is a way to make a difference.”

Family and Self-Management Support

Goal: Support families to manage the health care of their children

Change Concepts

Potential Strategies

1. Determine and incorporate relevant cultural healing traditions and beliefs into patient care and communication.

- Elicit patient/family's health beliefs and use of complementary and alternative medicine therapies during primary care visit.
- Perform assessments of patient/family self-management knowledge, supports, and barriers to good health.
- Use expertise from the community to educate providers and staff about cultural norms and values.

2. Prepare families to be engaged, empowered and educated so they are active partners in their child's care.

- Provide translated/interpreted informed consent.
- Use a care and treatment plan that is agreed upon and includes input from patient/family.
- Assess parental satisfaction with self-management materials.
- Include family input on teams working to tailor self-management tools.
- Provide all health materials and programs in a culturally and linguistically appropriate manner.
- Review and adapt existing translated material (e.g., asthma self-management plan) for use by communities served.

Obstacles and Challenges

As strong communication is at the core of providing family and self-management support, any language or literacy issue can be an obstacle. Written materials—whether in English or another language—are only useful if they are easily understood by the reader. Furthermore, it cannot be assumed that speaking a language also implies an ability to read in that language.

In some cultures, it is considered extremely impolite or disrespectful to question a person in a position of authority. If a provider asks a question such as, “Do you understand how to take your medication?” a nod or smile might seem the appropriate response regardless of the actual answer. Finding ways to successfully communicate with patients and families about care management is the main challenge here.

Successful Strategies

All practices interviewed provide translated or interpreted informed consent, most commonly in Spanish. Some sites went much further in engaging families in the development of language and literacy level-appropriate written materials. A community health center with several specialty clinics (asthma, ADHD, sickle cell anemia, obesity) used parent input in creating their materials. First, families were surveyed to get general feedback on written patient materials. Next, staff placed all available materials in a pile and asked parents to pick the ones they thought were the best. This was followed by a discussion about what was appealing to parents about the materials they had chosen.

Although none of the pilot sites had systematic ways of collecting information about health beliefs and the use of complementary and alternative medical treatments, most recognized the critical importance of the area and some had informal strategies that appeared effective. One provider noted, “This is important information to gather since many patients only come to me as a last attempt to get better after nothing else has worked.” Another provider reported asking routinely, “What have you done to treat your

illness so far?” before discussing treatment plans with patients.

There are several resources on the Web to obtain translated health materials. (Please see Resource list on page 33.) The most frequently used are the Vaccine Information Statements (VIS) from the Centers for Disease Control.

“This important NICHQ initiative successfully brought together experts working in the fields of quality improvement, children’s health care, cultural competency, and healthcare disparities. A promising ‘cultural competency change model’ was generated from the productive dialogue that should help improve the quality of care provided to children and their families from diverse backgrounds. Hopefully this exciting model will be fully tested and implemented in pediatric and primary care practices in California and throughout the nation.”

Robert C. Like, MD, MS

Associate Professor and Director
Center for Healthy Families and Cultural Diversity
Department of Family Medicine
UMDNJ-Robert Wood Johnson Medical School

Decision Support

Goal: Promote clinical care that is consistent with scientific evidence and family preferences

Change Concepts

1. Embed evidence-based guidelines into daily practice and share information with families to encourage participation in care.

2. Provide clinicians access to reliable resources for learning about health beliefs and practices of cultural groups in the community.

Potential Strategies

- Use, and tailor, as needed, evidence-based guidelines for all patient populations.
- Inform patients of the availability of guidelines pertinent to their care.

- Gather population demographics, epidemiological statistics about disparities in health and health care, prevalent health beliefs and healing traditions for predominant cultures served (e.g., breast feeding, parenting, immunizations.)

Obstacles and Challenges

Regardless of organizational size, the greatest challenge to gathering information about specific groups is the concern about these summaries leading to increased possibility of stereotyping. Pilot sites all recognized that no matter how comprehensive, any summary or list of beliefs or practice of a particular cultural group will not apply to all members of this group. Therefore, our pilot site contacts emphasized the importance of exploring with each individual patient or family the extent to which these generalizations accurately represent their own beliefs and practices.

Successful Strategies

Several sites shared guidelines as a standard part of providing care and presented the information either orally (interpretation) or in a written format (translated materials). In one clinic, the use of the guidelines was found to be particularly helpful when working with patients and families dealing with ADHD, obesity, asthma, and sickle cell anemia. For many encounters, a bilingual provider helped to convey this information.

Clinicians at several sites reported using several reliable resources for learning about the health beliefs and practices of specific cultural groups served. These sources included local health

departments — which were found to be quite useful by some pilot sites — and other resources such as Ethnomed, Kaiser Permanente’s providers’ handbooks, and the Cross-Cultural Health Care Program. Websites for each of these can be found in the resource section.

In addition, some smaller practices elicited demographic information from their patients. They also noted that several years of experience serving patients from a particular group gave them a very good understanding of the prevalent beliefs and traditions. Some small clinics report “go right to the source” and routinely ask patients to come to the office and share with staff and providers generalizations that might be useful regarding cultural health beliefs and traditions.

Delivery System Design

Goal: Assure the delivery of effective, efficient, patient-centered care

Change Concepts

Potential Strategies

1. Provide consumers with effective and respectful care compatible with their cultural beliefs and practices and in their preferred language.

- Use standardized questions or tools such as language cards for assessing preferred language.
- Use a standardized instrument to assess health literacy.
- Conduct informational sessions for staff to raise awareness of local health disparities as well as demographic and language trends.

2. Create an effective and efficient system to define roles and responsibilities regarding culturally effective care and distribute tasks among members.

- Incorporate language/interpreter needs at time of scheduling and when designing visits.
- Create and tailor group visits to address needs and preferences of communities, patients, and families served.

Obstacles and Challenges

Smaller pilot sites report having difficulty collecting data about language and interpreter needs because of difficulty in developing office systems and the prohibitive costs of interpreter services.

Successful Strategies

A solo practitioner in Washington state, one of the few states that will reimburse for interpreter services, reports this policy allows her to access interpreters for Medicaid patients. However, she felt she was not able to provide the same service for non-Medicaid patients because these costs are not reimbursed. As noted above, smaller sites often report relying on bilingual staff to avoid the cost of professional interpreters. As a note of caution in using untrained bilingual staff to interpret—one site reported that they found that their bilingual staff altered what was communicated by including their own opinions, rather than communicating either verbatim or the meaning of what was said by the patient or provider.

In larger systems, we found a greater effort to gather precise information about the primary language spoken by families and the need for an interpreter. Methods of identifying primary language spoken include standardized questions, as well as “ISpeak” cards and the use of world maps for patients to point to their language or country of origin. (Please see the Resource

section at the end of this publication for links to these materials.)

After identifying the primary language spoken, one organization uses a follow-up question to identify the primary language read in the home. This helps to clarify what language is needed for translated (written) materials.

In addition to providing interpreters for one-on-one appointments, some sites have begun to use group visits as a way to communicate with a large number of LEP patients who share a spoken language. For example, a solo practitioner organized group patient visits for Vietnamese patients all of whom were dealing with depression that was manifesting as physical symptoms such as back pain, headaches, and lethargy. She conducted group visits for back pain for these patients and used this as an opportunity to address not only the pain, but also underlying depression, in a way that was compatible with their cultural beliefs, practice, and in their preferred language.

Another clinic took a similar approach using its on-site dental clinic as a vehicle for Saturday morning group visits to meet with Spanish-speaking parents of toddlers. The children are given a basic dental exam and the parents are provided with information about dental care. Children with obvious decay or clear indicators for concern are scheduled for follow-up appointments.

Clinical Information System

Goal: Organize data to facilitate population-based care

Change Concepts

1. Create a standardized system to collect all relevant patient demographic data.

2. Use reports and data by relevant groups to provide feedback for staff, providers, and families.

Potential Strategies

- Incorporate demographic data into any existing Electronic Medical Record (EMR) or data system.
 - Ensure that data fields for race/ethnicity and language (at a minimum) are present in registration systems.
 - Train staff to use, collect, and input data into the organization's information system in a consistent, standardized way.
 - Use data to inform population-based and individual care.
 - Use data to monitor performance of practice team and health system.
-
- Link collected demographic and epidemiologic data with patient satisfaction surveys, provider feedback reports, and filed grievances and complaints.
 - Link demographic data with quality and patient safety measures, QI reports, and clinical outcomes.
 - Collect consistent information across sites and make universally available in the interest of comparison and care improvement.

Obstacles and Challenges

Many sites reported challenges in using standardized questions to collect race and ethnicity. For example, in one clinic, front desk staff and patient care coordinators felt that asking specific questions about race and ethnicity was too “intrusive” and not “politically correct.” Similarly, a large organization conducted meetings for several months to develop a statement to explain why these questions were being asked of patients. Unfortunately, these meetings ultimately resulted in a confusing and ambiguous statement that was not felt to be useful by the staff.

In our pilot studies, we found that if data collection were restricted to a paper system (e.g., entry into patient chart), it was difficult to link it to clinical and quality data that are electronically collected and monitored.

Using an electronic medical record with fields for entering race, ethnicity, and language has the potential to make data collection more uniform and consistent. However, sites using registries for

a common chronic illness (such as asthma) noted that the existing registries were lacking collection fields for race, ethnicity, or language data. For the purpose of quality improvement work, at a minimum patient registries should have the capability of capturing these fields. This will enable organizations to analyze group specific data for clinical outcomes and processes in order to determine the quality of care that is being provided.

Successful Strategies

To increase the staff's comfort level in asking patients and families questions about race and ethnicity, one pilot site reported that they are now conducting ongoing training to assure that this practice is integrated into the staff's routine. A couple of sites noted that providing staff a “script”—standard questions asked of each patient or family—was helpful.

NICHQ Measures for Cultural Competency

One of the key questions we ask in improvement work is, “How will we know that the changes being made are making things better?”

Tracking progress on specific measures related to the changes is one way to answer this question.

How will healthcare delivery organizations know if the changes they might make will lead to more culturally competent care? With input from experts in the field, as well as academic and clinical leaders in health care and cultural competency, we developed measures that delivery organizations can use.

These measures are grouped into “Core Measures,” those that are essential to meeting the goal of cultural competency, and “Additional Measures,” those that are important but somewhat less significant. The latter may be considered optional, to be chosen by providers who wish to use them.

There are three types of **Core Measures**.

Outcome measures show whether or not organizations are achieving their desired results. They are the ultimate voice of the patient. They report on the result of the change concepts and strategies in practice as they affect the patient’s experience and outcomes of care. This includes if their health is improved and if their subjective experience of receiving care is positive. Outcome measures reveal the effects of key changes.

Process measures let us know if the system is performing as planned. They are the voice of the system. They describe the process of care and the changes in service delivery; documentation of these processes can come from patients telling whether or not they receive care in their preferred language, or from clinical or administrative records, stating whether the need for an interpreter was documented.

Structural measures indicate whether the pre-conditions that are established are more likely to result in effective processes and better outcomes for children and families. Structural measures include the level of training of staff and the staff’s demographic characteristics.

Additional Measures include *balancing measures*. These measures tell us what is happening to the system as we make improvements in our outcome and process measures. They provide a perspective on the unintended side effects of

change throughout the system: Are you improving some part of the system at the expense of others, such as patient satisfaction or waiting times? Other additional measures assess processes and outcomes, but are not as central to the aim of achieving cultural competency and reducing disparities.

Looking at the full set of recommended measures may be daunting. We recognize that it is difficult to put several change strategies and measures into place at once. We have highlighted in this section three core measures that we consider—based on our expert judgment—the most important, as a starting point:

These are:

- *Disparities*: an Outcome measure to determine the magnitude of differences among racial/ethnic groups in key clinical outcomes. For example, do immunization rates among all children or rates of emergency department visits for kids with asthma differ among African-American, White, and Latino children?
- *Language*: a Process measure to determine the percentage of patients receiving care in their preferred language.
- *Identification of race, ethnicity, and language preference*: a Process measure to determine to what extent practices are identifying and tracking this information. Ideally, families should be asked to self-identify by answering standardized questions about race, ethnicity, and the preferred language for their health care encounters. It is preferable for providers to use the same categories used by the U.S. Census for assessing these characteristics.

Providers may wish to begin by first using these three core measures to assess their progress toward achieving the goal of reducing disparities in children’s health care, and then slowly add other recommended measures over time. The measures in the table are presented at a conceptual level; they would need to be precisely defined in any specific project.

Core Measures

Outcome Measures

Population Statistic

Disparities

Magnitude of difference among racial/ethnic groups in key clinical outcomes.

Process Measures

Population Statistic

Language

Percent of patients receiving care in their preferred language.

Interpreter need documented

Percent of calls for appointments in which interpreter need/desire is documented.

Interpreter provided

Percent of patient encounters requiring interpreter services that use trained and qualified medical interpreters.

Care plan

Percent of patients who require a care plan (i.e. patients with chronic illness) in their preferred language that is agreed upon and includes input and shared goals of the patient/family.

Identification of race/ethnicity and language preference

Percent of children/families with race/ethnicity, language preference, and desire for an interpreter identified in data system or in the medical record.

Structural Measures

Population Statistic

Bi/multilingual staff

Percent of providers and staff who speak the three primary languages of the patient population served.

Diverse staff

Percent of providers and staff who reflect the race/ethnicity of community served.

Staff trained in communication skills

Percent of staff who have completed training to develop communication skills, such as working with non-English speakers (through interpreters) or patients with poor literacy skills in the past 12 months.

Staff trained in cultural competency

Percent of staff who have completed trainings in cross-cultural health, diversity, or cultural competency in the past 12 months (e.g., CLAS and/or other standards).

Staff trained in interpreter use

Percent of staff trained in using interpreters (both trained and untrained).

Staff ability to access an interpreter

Percent of staff who know how to access an interpreter.

Additional Measures

<i>Measure</i>	<i>Population Statistic</i>
Condition-specific disparities	Percent of children with persistent asthma on preventive medications, according to race/ethnicity. (Outcome)
Health beliefs	Percent of visits in which providers elicited patient/family's health beliefs and use of complementary and alternative medicine therapies. (Process)
Referral	Percent of referrals with need for interpreter and preferred language documented in data system or in the medical record. (Process)
Staff training in LEP	Percent of staff trained in working with patients of limited English proficiency. (Structural)
Staff skills	Percent of staff assessed as having proficient level of cultural competence (in knowledge, skills, attitudes, and behaviors) in the past 12 months. (Structural)

<i>Balancing Measures</i>	<i>Population Statistic</i>
Experience of care	Percent of families reporting an excellent or very good "experience of care" from the three primary patient populations served.
Wait time	Wait time to get an interpreter (vs. wait time without an interpreter).
Visit time	Length of visit (time from check-in to departure) for interpreted encounters (vs. LEP encounters without an interpreter).

Pilot Test Summary

The pilot test process—both the survey and the actual implementation of change concepts—revealed several key findings. First, the implementation of many of the change concepts resulted in demonstrable improvements in care. Providing appropriately trained interpreters—even when available only telephonically—resulted in better communication, more appropriate diagnosis, and deeper understanding of patient needs. Exposing staff to cultural norms in particular populations brought about greater comfort in dealing with diversity and more effective treatment plans. Capturing data about race and ethnicity enabled programs to examine and address gaps in practice.

At the same time, pilot testing revealed that change in this area—like any change—poses challenges and requires overcoming obstacles. Interpreters, particularly trained interpreters, cost money, and in some settings delivery organizations may not be reimbursed for their services. The clinical and even financial benefits of such services may be less obvious to those making financial decisions. Capturing data about race and ethnicity may be uncomfortable for many in health care, and training is needed to make such data collection reliable.

Moreover, the obstacles are different—any may be quantitatively greater—in smaller organizations such as small private practices. Such organizations often cannot afford the outlays required to bring in additional staff or provide substantial training, but the flexibility and informality of such settings provide opportunity for innovation.

The methods of our pilot testing did not allow us to assess whether the tools of improvement, and particularly the use of incremental small tests of change while tracking progress to a larger goal, will be an effective approach. Nonetheless, the sites participating in our pilot study did develop innovative ways to make progress towards providing more culturally competent care. We are encouraged that the changes they began are making them more able to provide high quality care to patients from the diverse cultural communities of our nation.



Resources:

Useful Organizations and Websites

Organizations

The California Endowment

www.calendow.org

The Network for Multicultural Health

<http://futurehealth.ucsf.edu/TheNetwork/Default.aspx?tbid=387.html>

Office of Minority Health

www.omhrc.gov

National Center on Minority Health and Health Disparities, National Institutes of Health

<http://ncmhd.nih.gov>

Joint Commission on Accreditation of Hospital Organizations (JCAHO)

www.jcaho.org/accredited+organizations/long+term+care/standards/draft+standards/repl_fr_stds.pdf

Agency for Healthcare Research and Quality

www.ahrq.gov

The Commonwealth Fund

www.cmwf.org

HRSA

<http://bphc.hrsa.gov/quality/Collaboratives.htm>

National Business Group on Health

http://www.businessgrouphealth.org/prevention/health_disparities.cfm

National Center for Cultural Competence

www.gucchd.georgetown.edu/nccc

Center for Healthy Families and Cultural Diversity

www.umdnj.edu/fmedweb/chfcd

National Health Law Program

www.healthlaw.org

Hablamos Juntos

www.hablamosjuntos.org

Transcultural Nursing Society

www.tcns.org

California Pan-Ethnic Health Network

www.cpehn.org

Cross Cultural Health Care Program

www.xculture.org

National Initiative for Children's Healthcare Quality (NICHQ)

www.nichq.org

Related Efforts

Health Disparities Collaborative

www.healthdisparities.net/hdc/html/home.aspx

“Ask me 3 campaign”

www.askme3.org

Lumetra Health Plan's cultural competency effort

www.lumetra.com/healthplans/culturalcompetency/index.asp

Diversity Rx—Resources for Cross Cultural Health Care

www.diversityrx.org

Useful Tools

Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies

<http://futurehealth.ucsf.edu/TheNetwork/Default.aspx?tabid=290>

HRET—A Toolkit for Collecting Race, Ethnicity, and Primary Language Information

www.hretdisparities.org/hretdisparities/index.jsp

EthnoMed

<http://ethnomed.org>

Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda (CLAS Standards)

www.omhrc.gov/clas

Resources for Small Practice Settings to Provide Interpreter Services

“Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members”

California Academy of Family Physicians and CAFP Foundation

www.familydocs.org/mlc.html

“Providing Language Services in Small Health Care Provider Settings: Examples From the Field”

The Commonwealth Fund

www.cmwf.org/publications/publications_show.htm?doc_id=270667

Resources for Translated Health Education Materials and Forms

Healthy Roads Media

Fargo, North Dakota

www.healthyroadsmedia.org/index.html

Immunization Action Coalition (CDC)

<http://www.immunize.org/catg.d/noneng.htm>

Multicultural Health Communication Service,

New South Wales, Australia

www.mhcs.health.nsw.gov.au/health-public-affairs/mhcs/

Multilingual-Health-Education.net,

Vancouver, Canada

www.multilingual-health-education.net/#top

L.A. Care Health Plan,

Los Angeles, California

www.lacare.org/opencms/opencms/en/providers/document_search/index.html

References

¹ B.D. Smedley, A.Y. Stith, and A.R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press, 2002. www.iom.edu/report.asp?id=4475

² Flores, G., et al., “Racial and Ethnic Disparities in Early Childhood Health and Health Care” *Pediatrics*: February 2005;115 (2);183-193.

³ Lieu, T., et al., “Cultural Competence Policies and Other Predictors of Asthma Care Quality for Medicaid-Insured Children,” *Pediatrics*: July 2004; Vol. 114 No. 1: 102-111.

⁴ Fortier J. P., Bishop, D., 2003. *Setting the agenda for research on cultural competence in health care: final report*. Edited by C. Brach. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality.

⁵ *Crossing the Quality Chasm: A New Health System for the 21st Century*. Committee on Quality of Health Care in America, Institute of Medicine, National Academy Press, Washington, D.C., 2001.

⁶ Fortier, J., Convissor, R. & Pacheco, G. (1999). *Assuring Cultural Competency in Healthcare: Recommendations for National Standards and an Outcomes—Focused Research Agenda*. Office of Minority Health, U.S. Department of Health and Human Services.

* Fadiman, Anne, *The Spirit Catches You and You Fall Down*. Farrar, Straus and Giroux, 1998.

Culturally and Linguistically Appropriate Service (CLAS) Standards

1. Healthcare organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Healthcare organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Healthcare organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Healthcare organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Healthcare organizations should maintain a current demographic cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Healthcare organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

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