Importance of Cultural Competence in Health Care

By Marcia B. Smith, CHE Trinity Health, Des Moines, IA

Promoting diversity and inclusion in the health care setting is not just about reducing health care disparities. A number of health care systems, health plans, national associations, and states believe accounting for the diversity of patients and ensuring your board, clinicians, managers, and staff reflect, understand, and address this diversity will improve health care outcomes, increase patient satisfaction, and increase market share.[1]

Increased Diversity

The United States is becoming more ethnically diverse, and a significant percentage of its population has limited English proficiency.[2] According to the 2010 projections of the U.S. Census Bureau, the non-Hispanic white population will start to decrease in the next ten years, while the Hispanic, Black, Asian, and Native American populations will increase.[3] By 2043, the U.S. population will no longer be represented by a single majority group. While the non-Hispanic white population will remain the largest single group, no group will make up a majority. We also are more tolerant of recognizing other types of diversity, such as sexual orientation and religious preferences.[4]

National Standards for Culturally and Linguistically Appropriate Services

Health care organizations must effectively interact with their patients who come from different cultural and linguistic backgrounds. To address the lack of clear guidance on how to account for diversity in providing services, the U.S. Department of Health & Human Services, Office of Minority Health (OMH) developed in 2000 the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.[5] The CLAS Standards were enhanced in 2013 after a public comment period, a systematic literature review, and ongoing consultations with leaders and experts from the health care community. The enhanced CLAS Standards (see box) are designed to broaden the reach of cultural and linguistic competency at every point of contact in the health care continuum.

In the enhanced CLAS Standards, cultural competency is defined not just in terms of racial, ethnic, and linguistic groups, but also through geographical, religious, biological and sociological characteristics. There also is an explicit definition of health to include physical, mental, social, and spiritual well-being. In recognition of the variety of professionals and organizations furnishing health care and related services, the enhanced CLAS standards are applicable to any public or private institution addressing individual, family, or community health, health care, or well-being, including hospitals, clinics, skilled nursing facilities, and community health centers.[6]

To assist with implementation of the enhanced CLAS standards, OMH developed a "blueprint" for organizations to highlight promising practices and programs that have proved effective in other organizations.[7] The Blueprint provides an explanation of each standard's purpose and components, strategies for implementation, resources the organization can use to implement the standard, and a bibliography for further reference. For example, to recruit more diverse staff, the Blueprint suggests organizations advertise job opportunities in minority health professional associations' job boards and publications and recruit at minority health fairs.

Workforce Training

Training clinicians to recognize and address cultural diversity is fundamental to these efforts. New Jersey and Connecticut mandate that physicians undertake cultural competency training.[8] Other states mandate this for behavioral health care professionals.[9] OMH developed the Physician's Practical Guide to Culturally Competent Care to assist with these efforts.[10]

This type of training is not solely for the non-Hispanic white physician. With the increase in foreign-born physicians practicing in the United States, particularly in rural areas, organizations see an equal need to educate them about their patients.[11] Two professors at the University of Northern Iowa have developed a cultural competency course for foreign-born physicians at Mercy Medical Center in Mason City, IA.[12] The course content ranges from how to make small talk with their patients to Iowans' tendency to understate their pain levels, which is critical information when the physicians are diagnosing and treating their patients' ailments.

Regulatory and Accreditation Requirements

Effective communication is essential when furnishing health care services. Health care organizations that accept federal financial assistance, including grants and training, are required to take reasonable steps to ensure those patients with limited English proficiency can meaningfully access their services.[13] In the past, it was common practice to ask a minority child who was more proficient in English to interpret for his or her parent or grandmother. This practice is no longer accepted and could be considered a violation of the patient's civil rights.[14] Increasingly, hospitals are employing persons who can translate for the patients in their community and contracting with vendors to provide medical interpretation services if the patient speaks a foreign language and there is no one on site who is qualified to interpret medical terminology for the patient.[15]

Although adherence to the CLAS standards is voluntary, health care organizations should expect accreditation agencies to evaluate their efforts to address these issues. For example, The Joint Commission has established accreditation standards that directly or indirectly measure an organization's ability to provide culturally and linguistically appropriate services, particularly in the areas of improved communication, cultural competence, patient-centered care, and the provision of language-assistance efforts.[16]

The requirement to conduct a community health needs assessment (CHNA) is another inducement for tax-exempt hospitals to embrace these standards.[17] The CHNA process requires the hospital to define the community it serves, which necessarily includes the cultural and linguistic make-up of that community.[18] If a tax-exempt hospital is located in an area in which Hispanics are a significant percentage of the population, its CHNA should address how it will provide culturally and linguistically appropriate services to this population.

Like its members and the organizations they serve, AHLA values and seeks diverse and inclusive participation. The Diversity+Inclusion Council, under the leadership of its two co-chairs, Dot Powell-Woodson and Rob Niccolini, has invited liaisons from the other AHLA Councils and Committees to find ways to integrate the commitment to diversity and inclusion throughout the organization. Like the CHNA process, it is important for AHLA to know its members, so please take the time to complete your demographic profile on the AHLA website.[19]

Conclusion

Many organizations have embraced the CLAS Standards as a way to reduce health care disparities. This is an important goal. In the future, providers will compete based on quality and patient satisfaction, which means improving outcomes and patient satisfaction by advancing CLAS also should attract patients and improve the bottom line.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality-improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create processes for conflict and grievance resolution that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

About the Author

Marcia B. Smith (smitmars@mercyhealth.com) serves as Regional Counsel for CHE Trinity Health in the Iowa/Nebraska Region. Ms. Smith is responsible for overseeing legal matters for this eight-hospital system, which generates revenues of nearly $1 billion annually. Prior to joining CHE Trinity, Ms. Smith was a partner at a law firm in Albany, NY, and devoted her practice to representing health systems and other health care providers.

Endnotes

1 Howard K. Koh, M.D., M.P.H., J. Nadine Gracia, M.D., M.S.C.E., and Mayra E. Alvarez, M.H.A., *Culturally and Linguistically Appropriate Services — Advancing Health with CLAS,* New Eng. J. Med. (July 14, 2014), *available at* www.nejm.org/stoken/default+domain/Permissions-HHS/full#t=article.

2 According to the U.S. Census Bureau, about 8.7% of the U.S. population older than five years old believes they do not speak English "very well." Camille Ryan, *American Community Survey Reports, Language Use in the United States: 2011* (Aug. 2013), *available at* www.census.gov/prod/2013pubs/acs-22.pdf.

3 U.S. Census Bureau, 2012 National Population Projections, *available at* www.census.gov/population/%20projections/data/national/2012.html.

4 Pew Research Center, *Growing Support for Gay Marriage: Changed Minds and Changing Demographics* (Mar. 20, 2013), *available at* www.people-press.org/2013/03/20/growing-support-for-gay-marriage-changed-minds-and-changing-demographics.

5 U.S. Department of Health & Human Services, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (2013), *available at* www.thinkculturalhealth.hhs.gov.

6 *Id.*

7 U.S. Department of Health & Human Services, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (Apr. 2013), *available at* www.thinkculturalhealth.hhs.gov.

8 Conn. Gen. Stat. Ann. § 20-10b (West 2014); N.J. Stat. Ann.§ 45:9-7.2, 9-7.3 (West 2014). The Oregon Medical Board has the authority to mandate this training effective January 1, 2017. Or. Rev. Stat. Ann. § 676.850 (West 2014).

9 Ind. Code Ann. § 25-23.6-10.5-5 (West 2009); Ohio Rev. Code Ann.§ 4783.05 (West 2013); Ariz. Rev. Stat. Ann. § 32-3273 (2008); Cal. Bus. & Prof. Code § 4999.33 (West 2014).

10 U.S. Department of Health & Human Services, Office of Minority Health, *A Physician's Practical Guide to Culturally Competent Care, available at* www.thinkculturalhealth.hhs.gov.

11 See Kristin McCabe, *Foreign-Born Health Care Workers in the United States* (June 27, 2012), *available at* www.migrationpolicy.org/article/foreign-born-health-care-workers-united-states.

12 Sam Horsch, *Foreign-born doctors walk in Iowans' shoes* (Oct. 13, 2011), *available at* www.uni.edu/resources/features/foreign-born-doctors-walk-iowans-shoes.

13 Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d; 45 C.F.R. § 80.3(b)(2). Participation in Medicare Part B is not considered federal financial assistance. 68 Fed. Reg. 47311, 47313 (Aug. 8, 2003).

14 *See* 68. Fed. Reg. 47311, 47318 (Aug. 8, 2003).

15 *See, e.g.*, www.bannerhealth.com/Services/Health+And+Wellness/Ask+the+Expert/Your+Health+Care/_interpreters+in+the+hospital.htm.

16 The Joint Commission, *A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Joint Commission Hospital Accreditation Standards, available at* www.jointcommission.org/assets/1/6/Crosswalk-_CLAS_-20140718.pdf.

17 26 U.S.C. § 501(r).

18 *See, e.g.*, Connecticut Hospital Association and Connecticut Association of Directors of Health, *Guidelines for Conducing a Community Health Needs Assessment*, p. 21 (Mar. 2013), *available at* www.cdph.ca.gov/data/informatics/Documents/CT-cha-chna%20guidelines.pdf.

19 Find a link to the survey on the AHLA website at "Update Your Demographic Information," *available at* www.healthlawyers.org.

AHLA OFFICE CLOSURES

Thursday, November 27 and Friday, November 28

Thursday, December 25 and Friday, December 26, 2014

Thursday, January 1, 2015

PROBLEMS SOLVED... ISSUES PREVENTED.

Call us Toll Free 800 832-4144
or visit us at:
codingcompliance.com
Telephone: 248 661-9700
Facsimile: 248 661-9705

36524 Grand River Avenue
Farmington Hills, MI 48335