Importance of Cultural Competence in Health Care—Part Two

By Marcia Smith, Trinity Health, Des Moines, IA

A culturally competent health care system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care.[1]

In Part One of this article, I outlined the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and discussed positive reasons for embracing cultural competence—the carrots of improving health care outcomes, increasing patient satisfaction, and increasing market share.[2] In Part Two, I will explore further some of the sticks—civil rights complaints, medical malpractice claims, and accreditation standards.

Civil Rights Complaints

Health care providers who participate in the Medicare or Medicaid programs must ensure patients with limited English proficiency (LEP) can fully understand the medical advice they provide.[3] Patients with LEP have a limited ability to read, write, speak, and understand English. The U.S. Department of Health and Human Services, Office for Civil Rights (OCR) considers the failure to provide adequate language services at no cost to patients as national origin discrimination and a violation of Title VI of the Civil Rights Act.[4]

OCR receives and investigates complaints that patients are not receiving adequate language assistance. If the complaint is substantiated, OCR will typically enter into a voluntary resolution agreement with the provider or supplier.[5] These agreements require the provider or supplier to undertake some or all of the following corrective actions:

- Ensure oral interpretation and written translation services are provided to patients with LEP at no cost to the patient;
- Designate a language assistance coordinator;
- Appoint a community advisory board to advise on meeting the needs of patients with LEP;
- Ensure patients are notified of their right to free language assistance by posting notices in their commonly used languages in the admissions, registration, and emergency department areas;
- Publish its language assistance policy on its website;
- Translate written forms into commonly used languages;
- Issue medical cards to patients indicating their primary language;
- Conduct auditing and monitoring to determine the effectiveness of its language assistance program; and
- Conduct employee training.

The Centers for Medicare & Medicaid Services also requires providers who are applying for participation in the Medicare Part A program – including those seeking a change in ownership - to obtain a civil rights clearance from OCR.[6] The provider must submit an Assurance of Compliance Form and applicable policies and procedures, including procedures for effectively communicating with individuals with LEP. These policies should explain how the provider identifies patients with LEP, how interpretation services are provided, methods used to notify patients that interpretation services are available at no cost, restrictions on the use of friends and family as interpreters, and a list of forms available in other languages.

Medical Malpractice and Other Claims

One can envision the CLAS standards becoming the standard of care for assessing whether a health care provider has provided appropriate treatment of a culturally or linguistically diverse patient and obtained informed consent in a medical malpractice case. The CLAS standards governing communication and language assistance are certainly relevant to meeting these obligations. Providers must understand the patient's cultural context to correctly diagnose the patient, and the provider and patient must be able to communicate effectively in order for the patient to consent to and understand the risks and benefits of a proposed treatment.

This point is effectively demonstrated by one particularly unfortunate case. In 1983, Rita Patino Qunitero was found in Johnson City, KS, digging through trash cans and talking incoherently. She was oddly dressed and seemed to be claiming she "fell from the heavens."[7] She was taken to Larned State Hospital, a state psychiatric facility, where physicians diagnosed her as schizophrenic. To support their diagnosis, providers noted her unusual statements, her depression and aggression, and the fact she dressed in layers and refused to bathe.[8] While at Larned, she was treated with psychotropic medications and eventually developed tardive dyskinesia, a condition brought on by long-term use of psychotropic medications and characterized by involuntary movements.

After 12 years of hospitalization, Quintero was finally released in 1995 at the behest of the Kansas Advocacy & Protective Services (KAPS) agency.[9] They found a note in her file from 1983

indicating the Mexican Consulate in Salt Lake City told Larned personnel that Rita matched the description of a Tarahumara Indian, a northern Mexican tribe. KAPS convinced the hospital to release her and allow her to return to Mexico.

The Tarahumara, who dress in layers and prefer not to bathe regularly, migrate between Chihuahua's lowlands and uplands. Rita decided to undertake a personal migration that ended 800 miles later in Johnson City.[10] She tried to tell the police who picked her up that she came from the mountains around Chihauhua—pointing upwards toward the sky. She spoke no English and very little Spanish. Her native language, Rarámuri, is rarely spoken outside of Mexico, and does not have an alphabet. When she finally spoke to someone in her native language, she reportedly asked him to "please get me out of here."[11]

Quintero (through a conservator) and KAPS sued the numerous physicians, social workers, and psychologists who treated her, as well as the former and current superintendents of Larned, and the Secretary of the Kansas Department of Social and Rehabilitation Services.[12] They alleged she was wrongfully confined, was provided inadequate medical care, and never consented to the administration of psychotropic medication. Clearly, the Larned health care providers and officials did not provide effective, equitable, understandable, and respectful quality care and services and were not responsive to her cultural beliefs and language needs. As the court noted, at no time was a Rarámuri interpreter provided and "much of Ms. Qunitero's behavior that was treated with psychotropic drugs resulted from cultural differences, language barriers, the hospital environment, and the side effects of the psychotropic medications, rather than mental illness."[13]

Quintero's story is the subject of a play, written by one of Mexico's better-known playwrights, Victor Hugo Rascón Banda. The play is called "The Woman Who Fell From the Sky." Teatro Visión, a Chicano theater company in the Silicon Valley, staged the play in 2009 in English, Spanish, and Rarámuri. As one reviewer noted, the "story weaves together the chronological events of Qunitero's stay in the asylum, where her life becomes a hell of frustrated, inept doctors, abusive overmedication, cross-cultural intolerance and lack of communication."[14]

Accreditation Standards

U.S. health care providers pay to be accredited by third-party agencies, primarily because such accreditation will be deemed as compliance with the applicable Medicare conditions of participation.[15] The largest and best known accreditation agency is The Joint Commission, which accredits hospitals, home care providers, ambulatory and behavioral health facilities, and nursing homes. The Joint Commission fully supports the CLAS Standards and has developed a "roadmap" to inspire and show hospitals and other health care providers how to integrate language access and cultural competence into their organizations. The Roadmap for Hospitals provides recommendations to help hospitals address unique patient needs, meet the patient-centered communication standards, and comply with related Joint Commission requirements.[16]

So what are the "related Joint Commission requirements"? The Joint Commission crosswalk of the CLAS Standards to the Hospital Accreditation Standards lists 41 separate standards in eight different areas.[17] The three key areas are leadership; provision of care, treatment, and services; and rights and responsibilities of the individual.

The Joint Commission standards acknowledge the responsibility of a hospital's leaders (its governing body, senior management, and physician leaders) for ensuring the hospital provides services that meet the needs of its population. This requirement directly correlates to CLAS Standard #3: recruiting, promoting, and supporting a diverse governing body and other leaders. "Hospital governance is responsible for identifying and actualizing the institution's core mission and values."[18] When hospital governance is representative of the community it serves and is interested in and values cultural competence and the delivery of culturally and linguistically appropriate services, hospital managers will respond by enacting programs to improve cultural competency and ensure they have the necessary resources to succeed.[19]

In Trinity Health's Iowa Region, the regional board recently compared the ethnicity of its various service areas to the governing body of the entities operating in each area. It found that a number of these boards did not adequately reflect the ethnicity of the population they serve. The regional board adopted board development goals to address these gaps in 2016 by reaching out to community organizations and recruiting additional diverse members.

The Joint Commission standards also require providers to effectively communicate with patients and provide patient education and training based on the patient needs. These standards directly correlate to the CLAS standards regarding communication and language assistance and reflect the legal requirements discussed above. According to the Benchmark Study of U.S. Hospitals in 2013, most hospitals use agency or third-party interpreters to meet these requirements, but many are also training bilingual staff as formal interpreters.[20] In response to the high number of Spanish-speaking patients at its Pediatric Care Center in Kansas City, Children's Mercy Hospitals & Clinics created the CHICOS Clinic (Clinica Hispana de Cuidados de Salud), which trains pediatric residents with Spanish-language skills how to effectively communicate with the goal of developing certifiably bilingual and culturally sensitive clinicians.[21] The resi-

dents are encouraged to speak Spanish with the patients, with an interpreter in the room to ensure there is no confusion.

The CLAS Standards principal goal of providing care that is responsive to patient's cultural and language needs is reflected in The Joint Commission standards relating to the rights and responsibilities of the individual.[22] The hospital should respect, protect, and promote the patient's rights generally and should take specific steps to address the patient's culture and beliefs when providing treatment, even when the patient's cultural and religious beliefs lead her to be skeptical of the services you provide. Lancaster General Hospital in Lancaster, PA, which is home to more than 27,000 Amish people, is aware of and respectful toward their views of conventional Western medicine.[23] Lancaster General built bridges with the Amish community by partnering with them to provide farm safety day camps and in-home health education sessions. These efforts opened the door to addressing their other health issues through prevention, early detection, and proper use of integrative medicine.[24]

Conclusion

In addition to the benefits of improving access, promoting quality and reducing disparities, improving cultural competence also reduces legal and financial risk. Organizations that are culturally competent have less risk of civil rights complaints and medical malpractice claims and are in a better position to meet accreditation standards.

About the Author

Marcia B. Smith (smitmars@mercyhealth.com) serves as Regional Counsel for 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 Trinity Health, 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 Health Research & Educ. Trust, Inst. for Diversity in Health Mgmt, *Building a Culturally Competent Organization: The Quest for Equity in Health Care*, at p. 2 (July 2011) (hereinafter "Building a Culturally Competent Organization").
2 Marcia B. Smith, *Importance of Cultural Competence in Health Care*, 18 AHLA Connections 10 (Oct. 2014).
3 Title VI of the Civil Rights Act, 42 U.S.C. § 2000d; 45 C.F.R. § 80.3(b)(2).
4 *See* U.S. Dep't of Health and Human Svcs, Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. 47311 (Aug. 8, 2003).
5 *See* the sample voluntary resolution agreements *at* www.hhs.gov/ocr/civilrights/activities/examples/LEP/index.html.
6 CMS believes it has legal authority under Title XVIII of the Social Security Act to require health care providers to meet the legal requirements of the civil rights nondiscrimination statutes and regulations enforced by OCR in order to participate in the Medicare Part A program.
7 Jessica Fromm, *Teatro Visión Examines a Cultural Chasm in* 'The Woman Who Fell From the Sky', Metroactive (Jan. 28, 2009), *available at* www.metroactive.com/metro/01.28.09/stage-Fell-From-the-Sky-0904.html.
8 *Quintero v. Encarnación*, 242 F.3d 390 (10th Cir. 2000).
9 Dwight A. Corrin, *Not All Mexicans Speak Spanish*, Kan. City Star (June 11, 1996), *available at* www.indigenouspeople.net/tarahum1.htm.
10 Giles Slade, American Exodus: Climate Change and the Coming Flight for Survival (2013).
11 Veni Domine Iesu, *The Magical Feet of Rita Quintero*, (Feb. 11, 2012), *available at* http://conocetufe.blogspot.com/2012/02/los-pies-magicos-de-rita-quintero.html.
12 *Quintero, supra* note 8.
13 *Id.* at *3.
14 Fromm, *supra* note 7.
15 *See* 42 C.F.R. § 488.5 ("Institutions accredited as hospitals by the JCAHO or AOA are deemed to meet all of the Medicare conditions of participation for hospitals" with some exceptions).
16 The Joint Comm'n, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010).
17 The Joint Comm'n, *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* (July 2014) (hereinafter "Crosswalk").
18 Building a Culturally Competent Organization, *supra* note 1. at p. 5.
19 *Id.*
20 Health Research & Educ. Trust, Inst. for *Diversity in Health Mgmt, Diversity & Disparities: A Benchmark Study of U.S. Hospitals* (2013).
21 Am. Hosp. Ass'n, Ass'n of Am. Med Coll., Am. Coll. of Healthcare Exec, Catholic Health Ass'n, and Nat'l Ass'n of Pub. Hosp. and Health Sys., *Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned* (2012), at p. 8.
22 Crosswalk, *supra* 17, at p. 1.
23 Building a Culturally Competent Organization, at p. 12.
24 *Id.*