APPENDIX C: GUIDELINES AND KEY ASPECTS OF ORGANIZATIONAL SUPPORTS FOR CULTURALLY COMPETENT CARE

(BRACH & FRASER, 2000)

Nine techniques for cultural competence in health systems most frequently described in cultural competency literature (the authors' explanations are summarized):

- **Interpreter services.** Approaches to interpretation include on-site professional interpreters, ad hoc interpreters (staff members, friends and family members, strangers in the waiting room), and simultaneous remote interpretation with off-site professional interpreters.
- **Recruitment and retention.** Techniques for recruiting and retaining minority group members in health systems include 1) creating minority residency or fellowship programs, 2) hiring minority search firms, 3) adapting personnel policy to create a comfortable and welcoming workplace for minority group members, 4) mentoring minority employees by senior executives, 5) subcontracting with minority health providers, 6) tying executive compensation to steps taken to match hiring to community needs, 7) expanding on traditional affirmative action programs aimed at attracting employees who match the race and ethnicity of the patient populations, 8) establishing a set of principles for the respectful treatment of all people, 9) reviewing the fairness of human resource practices and compensation of all staff, and 10) tracking staff satisfaction by racial and ethnic groups.
- **Training.** Cultural competence training programs aim to increase cultural awareness, knowledge, and skills, leading to changes in staff behavior and patient-staff interactions. Training may be part of undergraduate or graduate medical education, an orientation process for new staff, or in-service training. It can also be a separate activity, either a regularly occurring activity, or a one-time occurrence, or by infusion, which integrates a multicultural perspective throughout a curriculum or training activities.
- **Coordinating with traditional healers.** Many minority Americans use traditional healers while they are seeking biomedical care. Clinicians need to coordinate with these healers as they would with any other care provider to ensure continuity of care and avoid complications owing to incompatible therapies. In addition, coordinating therapies with traditional ones may increase patient compliance.
- **Use of community health workers.** Members of minority communities can be used to reach out to other community members as well as to provide direct services such as health education

and primary care. They act as liaisons that bring in individuals in need of care, provide cultural linkages, overcome distrust, and contribute to clinician-patient communication, thereby increasing access to care.

- **Culturally competent health promotion.** In an attempt to make health-promotion efforts more culturally competent, culture-specific attitudes and values have been incorporated into messages and materials such as screening tools and public information campaigns.
- **Including family and/or community members.** Some minority groups believe that family members should be involved in health care decision making. Involving families and community members may be crucial in obtaining consent for and adherence to treatment.
- **Immersion into another culture.** Members of one cultural group may develop sensitivity and skills working with another culture by immersing themselves in that culture. It is reported that immersion enables participants to overcome their ethnocentrism, increase their cultural awareness, and integrate cultural beliefs into health care practices.
- **Administrative and organizational accommodations.** A variety of decisions related to clinic locations, hours of operation, network membership, physical environments, and written materials also can affect access to and use of health care. Health systems can make themselves more welcoming and accessible to minority patients.

(BUREAU OF PRIMARY HEALTH CARE, N.D.)

Guidelines for Assessing a Program's Cultural Competence (summarized)

- **Experience or track record of involvement with the target audience.** The organization should have a documented history of positive programmatic involvement with the population or community to be served.
- **Training and staffing.** The staff of the organization should have training in cultural sensitivity and in specific cultural patterns of the community proposed for services. Staff should be identified who are prepared to train and translate the community cultural patterns to other staff members. There should be clear, cultural objectives for staff and for staff development. Emphasis should be placed on staffing the initiative with people who are familiar with, or who are members of, the community to be served.
- **Community representation.** The community should be a planned participant in all phases of program design. A community advisory council or board of directors of the organization with decision-making authority should be established with members of the targeted cultural group represented.

- **Language.** If an organization is providing services to a multi-linguistic population, there should be multi-linguistic resources, including skilled bilingual and bicultural translators. Translated printed and audiovisual materials should be provided, and individuals who know the nuances of the language as well as the formal structure should do the translation.
- **Materials.** Audio-visual materials, public service announcements (PSAs), training guides, print materials, and other materials should be culturally appropriate for the community to be served. Pretesting with the target audience should provide feedback from community representatives about the cultural appropriateness of the materials under development.
- **Evaluation.** Evaluation methods and instruments should be consistent with cultural norms of the groups being served. The evaluation instruments chosen should be valid in terms of the culture of specific groups targeted for interventions. The evaluators should be sensitized to and familiar with the culture whenever possible.
- **Implementation.** There should be objective indicators that the organization understands the cultural aspects of the community that will contribute to the program's success and avoid pitfalls.

(COYE & ALVAREZ, 1999)

California's Medicaid managed care organization, Medi-Cal, instituted contract requirements for cultural competence that have had a substantial impact on health plan services and operations. The requirements have led to training programs and services designed to make health care access easier and health care services more effective for multiethnic populations. The following are key components from an early review of contract requirements and implementation:

- **Defining criteria for threshold populations.** Because of the great diversity of racial, ethnic, and linguistic groups served by Medi-Cal, plans and providers need a clear definition of the populations and service areas for which specialized services are required. Medi-Cal's threshold and concentration criteria appear to be useful toward this end.
- **Translation of plan materials.** Although the process of state approval is apparently cumbersome, it has spurred health plans to make their member services and health education materials uniformly available in languages appropriate to the needs of their members.
- **Complete access to interpreter services.** By requiring plans to provide 24-hour telephone access and establish protocols for scheduling interpreters when necessary, Medi-Cal has ensured a baseline availability of language services for beneficiaries.

- **Community participation in plan services development.** The establishment of community advisory committees has provided plan members with an organized framework for representing their needs and reviewing plan services. In addition, health plan staff gain insights from their direct interactions with members.
- **Development of training programs.** As plan services directors and provider organizations focus on meeting the needs of specific linguistic and cultural groups, administrators have recognized the need for more staff education, and all plans and provider organizations now have training programs.
- **Use of community health workers.** The implementation of contract requirements has led to increasing experimentation with the use of community health workers. Because of the limited time available between patients and clinical providers in most health care settings today, community health worker programs may offer an effective means of support for the health care management needs of all patients.
- **Use of plan surpluses.** Several Medi-Cal local initiatives reported plan surpluses at the end of their first year, which they allocated in part to community education, risk prevention, and disease management initiatives aimed at non-English speaking populations.
- **Minority physicians and traditional providers.** Medi-Cal policy calls for local initiatives to include traditional providers in their managed care networks. Mainstream plans reported that this process led them to expand their provider networks substantially.
- **Public hospitals and clinics.** The Medi-Cal managed care expansion plan proposed the development of local initiatives largely to ensure public and community hospital participation in managed care at levels adequate for these institutions to continue to receive Medicaid disproportionate share payments. The actual effect of this requirement, however, has been to maintain the availability of multicultural services at these hospitals.

(GOODE, 1999)

The National Center for Cultural Competence of the Georgetown University Child Development Center's checklist for organizations to help them to get started with planning, implementing and evaluating culturally competent service delivery systems in primary health care settings (summarized)

- Convene a cultural competence committee, work group, or task force within your program or organization that includes representation from policy making, administration, practice/services delivery, and consumer levels.

- Ensure that your organization's mission statement commits to cultural competence as an integral component of all its activities.
- Determine the racially, ethnically, culturally, and linguistically diverse groups within the organization's geographic locale. Assess the degree to which these groups are accessing services and their level of satisfaction.
- Determine the percentage of the population that resides in the geographic locale served by your organization affected by the six health disparities identified by HRSA (cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations). Collaborate with consumers, community-based organizations, and informal networks of support to develop approaches for delivering preventive health messages in a culturally and linguistically competent manner.
- Conduct a comprehensive program or organizational cultural competence self-assessment. Determine which instrument(s) and or consultant(s) best match the needs or your organization. Use the self-assessment results to develop a long-term plan incorporating cultural and linguistic competence into all aspects of your organization.
- Conduct an assessment of what organizational personnel perceive as their staff development needs related to the provision of services to racially, ethnically, culturally, and linguistically diverse groups.
- Convene focus groups or use other approaches to solicit consumer input on professional or staff development needs related to the provision of culturally and linguistically competent health care.
- Network and dialogue with other organizations that have begun the journey toward developing, implementing, and evaluating culturally competent service delivery systems. Adapt processes, policies, and procedures consistent with your organization's needs and encourage mechanisms to share training resources.
- Aggressively pursue and use available resources from federally and privately funded technical assistance centers that catalog information on cultural and linguistic competence, primary health care, and related issues (e.g., treatment, interventions, how to work with natural healers, outreach approaches, consumer education programs).
- Convene informal forums to engage organization personnel in discussions and activities to explore attitudes, beliefs, and values related to cultural diversity and cultural and linguistic competence.

- Identify and include budgetary expenditures each fiscal year to develop resources and to facilitate professional development through conferences, workshops, colloquia, and seminars on cultural and linguistic competence and other related issues.
- Gather and categorize resource materials related to primary health care and culturally diverse groups for use as references by organization personnel.
- Build and use a network of natural helpers, community informants, and other "experts" who have knowledge of the diverse groups served by your organization.
- Network with advocacy organizations concerned with specific health care, social and economic issues affecting racially, ethnically, culturally, and linguistically diverse communities. Solicit their involvement and input in the design, implementation, and evaluation of primary and community-based health care service delivery initiatives.

(LURIE & YERGAN, 1990)

Organizational goals for supporting training of medical residents to care for "vulnerable populations," whom the authors define as "those patients whom a substantial number of physicians regard as undesirable because they lack a means to pay for medical services, because they have medical problems that are difficult to manage, or because they have characteristics that give them low social status" (p. S27). Included in this definition are minority patients and non-English speakers. Goals for preparing residents to care for vulnerable populations include the presence of the following:

- A commitment to provide ambulatory as well as inpatient care for indigent patients and patients from other vulnerable groups.
- Adequate physician and non-physician staff to ensure that a satisfactory educational experience is provided for residents learning to care for these populations.
- Ongoing discussion of the ways (financial and other) in which departments and hospitals limit access to care.
- Individuals and institutions that model socially responsible provider behavior and recognition and support of faculty who do advocacy-oriented research on vulnerable population groups.
- A commitment to recruit and support faculty and house staff from racial and ethnic minority groups.
- Explicit learning objectives for teaching about the care of vulnerable populations in the ambulatory setting, and assurances that they are met.

(RUTLEDGE, 2001)

Major elements of an effective diversity or culturally competent plan:

- Acknowledge and accept the importance of delivering culturally competent care by including this principle in the institution's governing documents and adopting it in everyday operations.
- Ensure that all stakeholders—medical staff, employees, and volunteers—understand the institution's mission, vision, and values and how diversity and cultural competency are melded into those beliefs.
- Ensure that executives at the organization buy in and commit to this mission, vision, and values by including them in their individual goals and objectives and relating them to their compensation incentives.
- Address the issue of diversity at the departmental level, which is a precursor to promulgation of policies and value statements throughout the organization.
- Develop or revise policies, procedures, and/or operating principles.
- Carry out a comprehensive orientation of the workforce.
- Appoint an internal steering committee charged with developing a measurable diversity plan, which the board of directors is responsible for adopting. Members of this committee should represent both the clinical support and administrative functions of the institution. The committee's function can include but is not limited to (summarized):
  - conducting environmental assessment in cultural competence;
  - establishing a framework for integrating dimensions of cultural competence into all aspects of the organization;
  - developing an implementation strategy with timeline;
  - developing the orientation/educational process;
  - ensuring that policies and operating plan are carried out;
  - ensuring that each functional operating unit has an implementation plan; and
  - developing accountability measurements.