

**NQF**  
NATIONAL QUALITY FORUM



**CULTURAL  
COMPETENCY**



A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency

A CONSENSUS REPORT

## CULTURAL COMPETENCY STEERING COMMITTEE

**J. Emilio Carrillo, MD, MPH  
(Co-Chair)**

NewYork-Presbyterian Hospital and  
Healthcare System  
New York, NY

**Winston F. Wong, MD, MS (Co-Chair)**

Kaiser Permanente  
Oakland, CA

**Dennis P. Andrulis, MPH, PhD**

Center for Health Equality  
Drexel University  
Philadelphia, PA

**Francesca Gany, MD, MS**

Center for Immigrant Health  
New York University School of Medicine  
New York, NY

**Tawara D. Goode, MA**

National Center for Cultural Competence  
Georgetown University  
Washington, DC

**Sarah Hudson Scholle, DrPH, MPH**

National Committee for Quality Assurance  
Washington, DC

**Deeana L. Jang**

Asian and Pacific Islander American Health  
Forum  
Washington, DC

**Boris Kalanj**

Children's Hospitals and Clinics of Minnesota  
Minneapolis, MN

**Sunita Mutha, MD**

University of California, San Francisco  
San Francisco, CA

**Dula F. Pacquiao, EdD, RN**

University of Medicine and Dentistry  
New Jersey School of Nursing  
Newark, NJ

**Tanya Pagán Raggio-Ashley, MD, MPH**

Office of Minority Health & Health  
Disparities  
Health Resources and Services  
Administration  
Rockville, MD

**Marsha Regenstein, PhD**

School of Public Health and Health Services  
George Washington University  
Washington, DC

**Paul M. Schyve, MD**

The Joint Commission  
Oakbrook Terrace, IL

**Rachel Wallace Tellez, MD, MS**

American Academy of Pediatrics/Community  
Clinics, Inc.  
Silver Spring, MD

**Beverly A. Weidmer, MA**

RAND  
Santa Monica, CA

**Kimberlydawn Wisdom, MD, MS**

Henry Ford Health System  
Detroit, MI

**Mara K. Youdelman, JD**

National Health Law Program  
Washington, DC

**Consultant**

**Robert Weech-Maldonado, PhD, MBA**

University of Florida  
Gainesville, FL

## PROJECT STAFF

**Fatema Salam, MPH**

Senior Program Director

**Robyn Y. Nishimi, PhD**

Senior Advisor

**Nicole W. McElveen, MPH**

Program Director

**Helen Burstin, MD, MPH**

Senior Vice President,  
Performance Measures

# A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

## Foreword

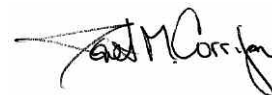
**EQUITY IS WIDELY ACCEPTED** as a core aim of healthcare quality. Yet, disparities in the provision of healthcare in the United States are severe and pervasive, despite widespread documentation and numerous attempts to address them. Racial and ethnic minorities face disproportionately higher rates of disease, disability, and mortality. African Americans have higher death rates from heart disease, diabetes, AIDS, and cancer, and American Indians and Alaskan Natives have lower life expectancies and higher rates of infant mortality.

In order to reduce disparities and improve outcomes, a number of healthcare organizations are exploring ways to improve cultural competency—that is, to ensure that diverse patient populations receive high-quality care that is safe, patient and family centered, evidence based, and equitable.

The National Quality Forum (NQF), an organization dedicated to improving healthcare quality, has endorsed 45 practices to guide healthcare systems in providing care that is culturally appropriate and patient centered. This report presents those practices along with a comprehensive framework for measuring and reporting cultural competency, covering issues such as communication, community engagement and workforce training, and providing healthcare systems with practices they can implement to help reduce persistent disparities in healthcare and create higher-quality, more patient-centered care. This framework and these preferred practices were vetted through NQF’s Consensus Development Process, granting them special legal status as voluntary consensus standards.

The aim to reduce disparities and create more patient-centered, culturally competent care directly aligns with the goals of the National Priorities Partnership—a diverse coalition of 28 major national organizations representing those who pay for, receive, provide, and evaluate healthcare. NQF is both the convener and a member of this coalition that was formed to transform healthcare from the inside out.

NQF thanks the Cultural Competency Steering Committee and NQF Members for their efforts in helping achieve a healthcare system that recognizes that truly high-quality care is also culturally competent care.



Janet M. Corrigan, PhD, MBA  
President and Chief Executive Officer

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

This work was supported by The California Endowment ([www.calendow.org](http://www.calendow.org)) and The Commonwealth Fund ([www.cmwf.org](http://www.cmwf.org)).

Recommended Citation: National Quality Forum (NQF). *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*. Washington, DC: NQF; 2009.

© 2009. *National Quality Forum*  
All rights reserved

ISBN: 978-1-933875-28-6

No part of this report may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means electronic, mechanical, photocopying, recording, or otherwise, without prior permission of the National Quality Forum. Requests for permission to reprint or make copies should be directed to:

Permissions  
National Quality Forum  
601 13th Street NW  
Suite 500 North  
Washington, DC 20005  
Fax 202-783-3434  
[www.qualityforum.org](http://www.qualityforum.org)

# A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

## Table of Contents

Executive Summary .....	v
Framework for Measuring and Reporting Cultural Competency .....	1
Introduction .....	1
Purpose .....	2
Defining Cultural Competency.....	2
Identifying the Framework .....	4
Purpose of the Framework .....	4
Guiding Principles .....	5
Framework Domains and Subdomains.....	5
Preferred Practices for Measuring and Reporting Cultural Competency .....	15
Introduction.....	15
Box A: Criteria for Evaluation of Practices .....	16
Table 1: Preferred Practices and Specifications Cross-Walked to the Framework.....	17
Domain 1: Leadership .....	24
Domain 2: Integration into Management Systems and Operations .....	28
Domain 3: Patient-Provider Communication .....	30
Domain 4: Care Delivery and Supporting Mechanisms .....	38
Domain 5: Workforce Diversity and Training .....	40
Domain 6: Community Engagement .....	42
Domain 7: Data Collection, Public Accountability, and Quality Improvement .....	45
Areas Recommended for Further Research .....	50
Table 2: Areas Recommended for Further Research .....	50
Relationship to Other NQF-Endorsed Consensus Standards .....	51
References.....	52

Appendix A— Commissioned Paper: A Cultural Competency Framework  
for Quality Measurement and Reporting ..... A-1

Appendix B— Glossary ..... B-1

Appendix C— Implementation Examples Cross-Walked to Practices ..... C-1

# A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

## Executive Summary

*We envision healthcare that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances and differing cultures, languages, and social backgrounds.*

—National Priorities Partnership, 2008

**FOR TOO LONG**, healthcare received by minority populations has been of poorer quality—even when factors such as access, health insurance, and income are taken into account. Unless these inequities are addressed and care becomes more patient centered, these disparities in health and healthcare will persist.

One major contributor to healthcare disparities is a lack of culturally competent care. Even as healthcare systems improve, without the provision of culturally appropriate services, medical errors, misunderstandings, and a lack of patient adherence may still increase because of differences in language or culture. Providing culturally appropriate services not only has the potential to reduce disparities and improve outcomes, but it also can create greater patient satisfaction and help to increase the efficiency of clinical and support staff.

Healthcare cannot be of high quality without being delivered in a culturally competent manner. This National Quality Forum (NQF) report, *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency*, aims to promote culturally competent care, to reduce disparities, and to make care more patient centered. It does so by endorsing a comprehensive framework—a road map—for measuring and reporting cultural competency. It also endorses a set of 45 preferred practices to provide culturally competent care.

Overarching the framework are four guiding principles for measuring and reporting cultural competency. These principles are intended to be cross-cutting and to provide broad themes and direction that promote standardized measurement and reporting of cultural competency, drive practice improvement and measure development in cultural competency, and support implementation of policies and programs to improve cultural competency:

- Cultural competency in healthcare embraces the concept of equity, with patients having equal access to quality care and nondiscriminatory, patient-centered practices delivered by healthcare providers.
- Cultural competency is necessary, but not sufficient, to achieving an equitable healthcare system.
- Cultural competency should be viewed as an ongoing process and a multilevel approach, with assessments and interventions needed at the system, organizational, group, community, and individual levels. Cultural competency should not be viewed as an endpoint; rather, communities, organizations, and individuals should strive for continuous improvement.
- The successful implementation of cultural competency initiatives to achieve high-quality, culturally competent, patient-centered care requires an organizational commitment with a systems approach toward cultural competency. Addressing both organizational and clinical aspects when managing diversity and the needs of a diverse workforce, the surrounding community, and the patient population are important factors in providing culturally competent care.

The NQF-endorsed<sup>®</sup> framework for cultural competency establishes a conceptual model to identify and organize preferred practices and performance measures based on a set of seven interrelated domains (and multiple subdomains)

that are applicable to all settings and providers of care. Specifically, the seven primary domains for measuring and reporting cultural competency are:

1. **Leadership.** Leadership recognizes that healthcare providers, clinical and organizational leaders, the governance board, and the community share responsibility for and play an essential role in the development and implementation of cultural competency activities, in setting policy and strategy, and in monitoring organizational performance. Leadership must aspire to reflect the diversity of the community served.
2. **Integration into Management Systems and Operations.** Focusing on whether cultural competency is integrated throughout all management and operations activities of the organization is an essential component of supporting the delivery of culturally competent care.
3. **Patient-Provider Communication.** Clear communication at all levels and at all times among patients, clinicians, and support staff is essential for effective and culturally competent care.
4. **Care Delivery and Supporting Mechanisms.** From the first encounter to the last, care delivery structures and supporting mechanisms—the delivery of care, the physical environment where it is delivered, and links to supportive services and providers—should support the provision of culturally competent care.
5. **Workforce Diversity and Training.** Ensuring workforce diversity and training is a way to provide more effective services for culturally diverse populations through proactive recruitment, retention, and promotion strategies. Diversity at all levels of the organization is important. Training and development activities should include state-of-the-art content in cultural competency and should reflect organizational commitment to cultural competency.



**6. Community Engagement.** Active outreach and the exchange of information, as well as community inclusion and partnership in organizational decisionmaking, help ensure the provision of culturally competent care.

**7. Data Collection, Public Accountability, and Quality Improvement.** Organizations use these methodologies to collect the data needed to assess their cultural competency, to assess whether they perform routine self-assessments in this regard, and to assess whether they integrate cultural competency into their public accountability and quality improvement activities.

The framework is intended for all healthcare organizations—health plans, hospitals, small and large physician group practices, community-based organizations, clinics, nursing homes, dialysis centers, ambulatory care centers—

delivering care, including mental health services and oral health.

Although the framework provides organizational structure for measuring and reporting the quality of providing culturally competent care, significant advancement in this area requires systematic deployment of a comprehensive set of preferred practices—and ultimately performance measures—that address the framework’s domains. The 45 practices endorsed in this report will improve the quality of care through cultural competency and address the vision of the National Priorities Partnership. They can also serve as the basis for identification and/or development of quality measures that can be used for public accountability for the delivery of culturally competent care.

---

## A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency

---

### Domain 1: Leadership

- **Preferred Practice 1:** Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.
- **Preferred Practice 2:** Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.
- **Preferred Practice 3:** Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.
- **Preferred Practice 4:** Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.
- **Preferred Practice 5:** Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.

*more*

---

## A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency

---

### Domain 1: Leadership (continued)

- Preferred Practice 6: Commit to cultural competency through systemwide approaches that are articulated through written policies, practices, procedures, and programs.
- Preferred Practice 7: Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

### Domain 2: Integration into Management Systems and Operations

- Preferred Practice 8: Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.
- Preferred Practice 9: Implement language access planning in any area where care is delivered.
- Preferred Practice 10: Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.
- Preferred Practice 11: Market culturally competent services to the community to ensure that communities that need services receive the information.

### Domain 3: Patient-Provider Communication

- Preferred Practice 12: Offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
- Preferred Practice 13: Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.
- Preferred Practice 14: Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.
- Preferred Practice 15: Translate all vital documents, at a minimum, into the identified threshold languages for the community that is eligible to be served.
- Preferred Practice 16: Translate written materials that are not considered vital when it is determined that a printed translation is needed for effective communication.

---

*more*

---

## A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency

---

### Domain 3: Patient-Provider Communication (continued)

- Preferred Practice 17: Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document.
- Preferred Practice 18: Use “teach back” as a patient engagement tool to enhance communication between the healthcare provider and the patient during clinical encounters.
- Preferred Practice 19: Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.
- Preferred Practice 20: Regularly assess attitudes, practices, policies, and structures of all staff as a necessary, effective, and systematic way to plan for and incorporate cultural competency within an organization.
- Preferred Practice 21: Include family members in healthcare decisions, when requested by the patient, when providing care for culturally diverse populations.

### Domain 4: Care Delivery and Supporting Mechanisms

- Preferred Practice 22: If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.
- Preferred Practice 23: Develop and implement a comprehensive care plan that addresses cultural concerns.
- Preferred Practice 24: Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.
- Preferred Practice 25: Adapt the physical environment where the healthcare is being delivered to represent the culture of the populations who access their healthcare in that environment.
- Preferred Practice 26: Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.
- Preferred Practice 27: Explore, evaluate, and consider the use of multimedia approaches and health information technology to enable the provision of healthcare services that are patient and family centered and culturally tailored to the patient.

---

*more*

---

## A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency

---

### Domain 5: Workforce Diversity and Training

- Preferred Practice 28: Recruit and hire ethnically diverse providers and staff at all levels, including management levels.
- Preferred Practice 29: Actively promote the retention of a culturally diverse workforce through organizational policies and programs.
- Preferred Practice 30: Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.

### Domain 6: Community Engagement

- Preferred Practice 31: Engage communities to ensure that healthcare providers (individual and organizational) are aware of current and changing patient populations and cultural and communication needs and provide opportunities to share resources and information.
- Preferred Practice 32: Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.
- Preferred Practice 33: Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating the effectiveness of cultural competency activities.
- Preferred Practice 34: Healthcare professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.
- Preferred Practice 35: Use the methodology of community-based participatory research when conducting research in the community as a collaborative approach to research that equitably involves all stakeholders in the research process and fosters the unique strengths that the community brings to the process.

### Domain 7: Data Collection, Public Accountability, and Quality Improvement

- Preferred Practice 36: Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner.
- Preferred Practice 37: Ensure that, at a minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.

---

*more*

---


## A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency

---

### Domain 7: Data Collection, Public Accountability, and Quality Improvement (continued)

- **Preferred Practice 38:** Utilize indirect data collection methodologies (e.g., geocoding, surname analysis) to characterize the race, ethnicity, and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.
- **Preferred Practice 39:** Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.
- **Preferred Practice 40:** Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.
- **Preferred Practice 41:** Publicly report data for the applicable NQF-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care stratified by race/ethnicity and primary written and spoken language.
- **Preferred Practice 42:** Regularly make available to the public information about progress and successful innovations in implementing culturally competent programs (especially the NQF-endorsed preferred practices for cultural competency), and provide public notice in communities about the availability of this information.
- **Preferred Practice 43:** Assess and improve patient- and family-centered communication on an ongoing basis.
- **Preferred Practice 44:** Any surveys created by or conducted by the organization must collect race, ethnicity, and primary written and spoken language, and analysis and results must be stratified by race, ethnicity, and primary written and spoken language.
- **Preferred Practice 45:** Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.





# A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

## Framework for Measuring and Reporting Cultural Competency

### Introduction

**RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE** are well documented and indicate that minorities disproportionately suffer from higher rates of disease and death and tend to receive a lower quality of care even when factors such as access, health insurance, and income are taken into account.<sup>1</sup> The Institute of Medicine (IOM) addressed this issue in its report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* and noted that one major contributor to disparities in health and healthcare is a lack of culturally competent care.<sup>2</sup> Providing culturally appropriate services has the potential to not only reduce disparities and improve outcomes, but it also can help to increase the efficiency of clinical and support staff as well as create greater satisfaction among patients.<sup>3</sup>

Efforts to define and classify cultural competency are ongoing. In 2001, the Department of Health and Human Services (DHHS) Office of Minority Health published standards for culturally and linguistically appropriate services (CLAS) for healthcare organizations.<sup>4</sup> These standards were an initial effort to provide structure to what constitutes culturally appropriate healthcare services: The National Committee for Quality Assurance (NCQA) now has an awards program for health plans that demonstrate innovative approaches in meeting CLAS standards. In addition, policy level approaches for cultural competency have been introduced by The Joint Commission and the Centers for Medicare & Medicaid Services. The Joint Commission has a project to develop hospital accreditation standards to promote, facilitate, and incentivize the provision of culturally competent, patient-centered care, and NCQA has been working to develop a module of standards suitable for evaluating efforts to improve the provision of culturally and linguistically appropriate services and to identify and reduce care deficiencies.

Developing culturally competent healthcare systems is an integral and vital component in reducing disparities and delivering patient-centered care. Moreover, even as healthcare systems improve, without the provision of culturally accurate and appropriate services, medical errors, misunderstandings, and a lack of patient adherence may still increase because of differences in language or culture. This project aims to promote culturally competent care and to reduce disparities by endorsing a comprehensive framework for measuring and reporting cultural competency and by endorsing preferred practices to provide culturally competent care. As is true for all National Quality Forum (NQF)-endorsed<sup>®</sup> products, the framework and practices presented in this report will be reviewed and revised as the evidence base and field of cultural competency evolve.

## Purpose

The purpose of this project was to:

- endorse a *comprehensive* national framework for evaluating cultural competency across all healthcare settings;
- endorse a minimum set of preferred practices for cultural competency based on the framework. These practices are both specific and overarching—that is, they cover all settings and providers; and
- identify high-priority research areas to advance the evaluation of cultural competency and its impact on care.

## Defining Cultural Competency

Over the past decade, cultural competency has had a range of meanings.<sup>5</sup> For the purposes of this project, NQF's definition of cultural competency is intended to address both its individual and organizational aspects, as well as its structural and process elements:

Cultural competency is the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient<sup>i</sup> populations high-quality care that is safe, patient and family centered, evidence based, and equitable.

Healthcare cannot be of high quality without being delivered in a culturally competent manner.<sup>ii</sup> In 2001, IOM's report *Crossing the Quality Chasm: A New Health System for the 21st Century* outlined six aims for the quality of healthcare—that it should be safe, effective, patient centered, timely, efficient, and equitable.<sup>6</sup> High-quality care is state-of-the-art care that is grounded in evidence-based clinical practices. According to IOM's<sup>7</sup> equity aim for health system improvement, the quality of care a patient receives should not differ because of characteristics such as gender, race, age, ethnicity, income, education, disability, sexual orientation, or location of residence. However, although the quality of the care should not differ, the care is patient centered only when clinicians treat and respect each patient as an individual, within the context of his or her care.<sup>8,9</sup> This requires a partnership among clinicians, patients, and families to ensure that

<sup>i</sup> The term *patient* refers to the individual recipient of care—that is, patient, client, legal surrogate, or person.

<sup>ii</sup> High-quality healthcare is delivered in a safe, effective, patient-centered, timely, efficient, and equitable manner and is state of the art and evidence based.



healthcare decisions take into account patient preferences. In order to be patient centered, evidence based, and equitable, culturally competent healthcare requires oral and written language access, sensitivity to cultural differences, and attention to patients' health literacy needs. The delivery of culturally competent care should not focus on one specific clinical encounter, but rather should relate to the health and illness problems experienced by individuals and their families across their life span.

Cultural competency is achieved through the implementation and use of policies, learning processes, and structures by which organizations and individuals develop and support the attitudes, behaviors, practices, and systems that are needed for effective cross-cultural interactions. Factors that can effect cross-cultural interactions include but are not limited to sociocultural factors such as race/ethnicity, nationality, language, health literacy, gender, socioeconomic status (SES), immigrant status (age at immigration and length of time in the United States), physical and mental ability, mental health, sexual orientation and gender identity, religion, age, and occupation.<sup>10</sup> These factors can be conceptualized as cultural group identities. Individuals' affiliations to cultural groups are complex, with individual differences based on the group identity profile and strength of the group identities.<sup>11</sup> For example, a second-generation Hispanic patient of higher SES may have a different cultural reference point than a recent Hispanic immigrant of lower SES. That is, the group identity profile, as well as the strength of group identities, is likely to differ, and these differences may affect an individual's interactions with the healthcare system.

It is important to note that children's cultural experiences and identities can be and are frequently different from those of their parents.<sup>12</sup> For the most part, there are no substantial differences between adults and children with respect to receiving culturally competent care that pertain to the preferred practices presented in this report, and the use of the terms "patients" and "patients and families" includes children. Nonetheless, children are a distinct population that may have divergent needs from those of their parents. For example, a child raised in the United States may have a very different cultural experience from his or her first-generation immigrant family. In infancy and early childhood a child's culture will be more reflective of his or her family, and the clinical encounter will generally be addressed to the caregiver alone. As the child grows into middle and late childhood, however, he or she is exposed to beliefs, values, cultural practices, and languages that are different from those that the parents experienced. The clinical encounter will gradually transition to include the child, and, by late adolescence, it will be focused on the adolescent alone. This is a complex transition not only because of the autonomy issues of the increasingly independent adolescent, but also because the child is likely to have health beliefs that differ from those of the family. Thus, in the pediatric population, communication must be family centered *and* child centered in a developmentally appropriate manner.

Additionally, NQF recognizes that individuals with physical, cognitive, or emotional disabilities experience many of the same barriers to high-quality, safe care as do those who have limited English proficiency (LEP) or those who are from

other cultural backgrounds. Groups that share a particular disability—such as limitations in sight, hearing, speech, or mobility—often share a unique culture among themselves, such that communication and cultural differences are also sources of barriers to their healthcare. The identification of preferred practices to reduce or eliminate these barriers was beyond the scope of this project. However, the project's Steering Committee strongly recommended that an additional report to address these barriers be developed under the guidance of a new, appropriately constituted Steering Committee that represents the knowledge and experience needed to address cultural barriers resulting from physical, cognitive, or emotional disabilities.

## Identifying the Framework

A Steering Committee guided the development of an evidence-based framework,<sup>iii</sup> relying on a paper commissioned for NQF, “A Cultural Competency Framework for Quality Measurement and Reporting” (Appendix A).

## Purpose of the Framework

Despite research efforts to build an evidence base for cultural competency that would result in improved health outcomes and decreased system costs, there is a noticeable absence of a broadly defined framework, logic model, or

definition that would move the field beyond race- or ethnic-specific interventions.<sup>13</sup> A nationally endorsed framework around cultural competency can serve as a road map for the identification of a set of preferred practices and performance measures, as well as for the identification of areas requiring additional research or development. The evidence-based framework establishes a conceptual model to identify and organize NQF-endorsed preferred practices and performance measures based on a set of interrelated domains and subdomains that are applicable to multiple settings of care and providers of care. The framework also serves as the basis to assess what is currently available and to identify areas where gaps in practices exist. Guided by the framework, a set of preferred practices, which are presented in this report, and measures, which will be endorsed based on this work, should provide comprehensive evaluation and reporting tools to ensure that care is delivered in a culturally competent manner.

The framework is intended to be comprehensive and applicable to all healthcare settings and all providers of healthcare, as are the 45 preferred practices that comport to the framework. Although some of the specifications may be more easily implemented within larger healthcare facilities or large physician group practices than in smaller settings, they can be adapted to also work, for example, in a single physician's office, a small rural hospital,

<sup>iii</sup> This framework is intended for all healthcare organizations (health plans, hospitals, small and large physician group practices, community-based organizations, clinics, nursing homes, dialysis centers, ambulatory care centers) delivering care, including mental health services and oral health. Its audience is all employees of those organizations. For the purposes of this framework, healthcare professionals are defined as physicians, administrators, nurses, physical and occupational therapists, linguistic services providers, psychologist social workers, and others who provide care to a patient.

nursing homes, or home health agencies. The expectation is that individual offices and organizations will prioritize and implement the framework, and, in particular, the practices, as best suited for their short- and long-term needs. Additionally, NQF notes that the public health community plays an important role in delivering culturally competent care. However, although many of the framework domains and subdomains, principles, and practices are applicable to the public health community, the scope of this project is focused on the healthcare delivery system.

## Guiding Principles

Guiding principles for measuring and reporting cultural competency provide broad themes and direction that, if uniformly adopted by all stakeholders, promote standardized measurement and reporting, drive practice improvement and measure development, and support implementation. The guiding principles are intended to be overarching and/or cross-cutting across all (or multiple) domains of the framework presented below.

The four guiding principles are as follows:

### Principle 1.

Cultural competency in healthcare embraces the concept of equity, with patients having equal access to quality care and nondiscriminatory, patient-centered practices delivered by healthcare providers.

### Principle 2.

Cultural competency is necessary, but not sufficient, to achieving an equitable healthcare system.

### Principle 3.

Cultural competency should be viewed as an ongoing process and a multilevel approach, with assessments and interventions needed at the system, organizational, group, community, and individual levels.<sup>14,15</sup> Cultural competency should not be viewed as an endpoint; rather, communities, organizations, and individuals should strive for continuous improvement.<sup>16</sup>

### Principle 4.

The successful implementation of cultural competency initiatives to achieve high-quality, culturally competent, patient-centered care requires an organizational commitment and a systems approach toward cultural competency.<sup>17,18,19</sup> Addressing both organizational and clinical aspects when managing diversity and the needs of a diverse workforce, the surrounding community, and the patient population are important factors in providing culturally competent care.<sup>20</sup>

## Framework Domains and Subdomains

Standardizing the measurement and reporting of cultural competency requires the identification of a comprehensive framework that delineates the domains of high-quality, culturally competent care. From this framework, preferred practices can be identified—and from those practices, measures can be developed. Gaps in practices (or measures) should be readily identifiable based on this approach.

The seven primary domains of measuring and reporting cultural competency are as follows:

1. Leadership
2. Integration into Management Systems and Operations
3. Patient-Provider Communication
4. Care Delivery and Supporting Mechanisms
5. Workforce Diversity and Training
6. Community Engagement
7. Data Collection, Public Accountability, and Quality Improvement

Each domain includes subdomains that further delineate the components. Although the subdomains are included among distinctive domains, many of them are cross-cutting and could be applicable in other domains.

## DOMAIN 1

**Leadership.**<sup>iv</sup> Leadership recognizes that healthcare providers, clinical and organizational leaders, the governance board, and the community share responsibility for and play an essential role in the development and implementation of cultural competency activities, in setting policy and strategy, and in monitoring organizational performance. Leadership must aspire to reflect the diversity of the community served.

### Subdomain 1.1

**Organizational Culture.** Organizational culture should be inclusive and should value cultural differences. Being inclusive signifies that the organization's decisionmaking processes include diverse points of views from both within and outside the organization. When an organization values diversity, that diversity is demonstrated in its practices, structure, and

policies. The leaders of an organization are instrumental in setting organizational culture.<sup>21</sup>

### Subdomain 1.2

**Commitment to Serving a Diverse Population.** Cultural competency activities are most effective when the organization's top management, governance boards, executives, and policymakers embrace cultural competency and diversity and communicate this support throughout the organization and the community.<sup>22,23</sup>

### Subdomain 1.3

**Leadership Diversity.** Leadership at all levels of the organization, including clinical and administrative leaders and the governance board, reflects the community.<sup>24</sup> Diversity is critical at the department chief and chair levels. Leadership diversity increases the likelihood that the needs of a diverse workforce and patient population are taken into account in organizational decisionmaking processes.<sup>25</sup> However, minorities have traditionally faced barriers, or a "glass ceiling" effect, that have excluded them from upper management positions.<sup>26</sup> As such, healthcare organizations need to adopt and use proactive human resource strategies aimed at diversifying the leadership ranks.

### Subdomain 1.4

**Dedicated Staff and Resources.** An organization demonstrates its commitment to cultural competency by dedicating resources and designating staff for activities that promote cultural competency. Dedicated resources can be shown by budgeting them for cultural competency activities.<sup>27,28,29</sup> Dedicated staff can include an executive-level staff member, a department, or an office that focuses on multi-cultural and/or linguistic issues. This can be

<sup>iv</sup> This domain refers to leadership by the board of directors, trustees, and C-suite level and senior managers.

instrumental in coordinating organization-wide initiatives and monitoring progress toward cultural competency goals.<sup>30,31</sup>

### **Subdomain 1.5**

**Policies.** Formal policies are needed that address cultural competency issues, such as the recruitment and retention of a diverse workforce and the provision of language services and training and development.<sup>32,33</sup> Policies “express an organization’s intentions and provide a blueprint for action.”<sup>34</sup> These internal policies should be in conformity with external regulatory and statutory policies.<sup>35</sup>

### **Subdomain 1.6**

**Training and Development.** The training and development of leaders and staff on cultural competency issues is needed at all levels of the organization, including the governance board.<sup>36</sup> Leadership participation in training and development sends a signal to organization members about its commitment to cultural competency. (See also Domain 5: Workforce Diversity and Training.)

## **DOMAIN 2**

**Integration into Management Systems and Operations.** Focusing on whether cultural competency is integrated throughout all management and operations activities of the organization is an essential component of supporting the delivery of culturally competent care.

### **Subdomain 2.1**

**Strategic Planning.** The strategic planning process includes environmental scanning, asset assessment, and needs assessment of the communities served and the formulation of goals related to cultural competency.<sup>37</sup> Strategic goals reflect the organization’s priorities for resource use and deployment.

### **Subdomain 2.2**

**Service Planning.** Organizations should design services that take into account the needs of the patient populations they serve. This includes all elements of the healthcare encounter, including the greeting of patients, referrals to other services, admission to discharge planning, and encounters with support staff, with the ultimate goal of improving access to care for all patients<sup>38</sup> (e.g., providing child care or transportation services; expanding operating and clinical hours to accommodate community work patterns; adapting to ethnic or religious dietary preferences; and allowing for large families visiting or staying with hospitalized patients).<sup>39,40</sup>

### **Subdomain 2.3**

**Performance Evaluation.** Job descriptions and performance evaluation systems should include criteria related to cultural competency,<sup>41,42</sup> and the performance evaluation process should include a survey of patient and family experience with care. This results in accountability for meeting cultural competency goals. (See also Domain 7: Data Collection, Public Accountability, and Quality Improvement.)

### **Subdomain 2.4**

**Reward Systems.** Managers and staff should be rewarded for meeting cultural competency goals.<sup>43</sup> Incentives help align the goals of an organization’s members with those of the organization: Behavior or performance that is positively reinforced tends to be repeated.<sup>44</sup>

### **Subdomain 2.5**

**Marketing and Public Relations.** Organizations promote and market their services through a variety of media that reach out to diverse populations. These media include ethnic newspapers, television news

programs, and radio stations.<sup>45</sup> Marketing and social marketing also should emphasize the types of services offered, such as those involving interpretation and translation, as well as other cultural services. Performance and quality information should be publicly reported, should include patient experience with care, and should be presented in a format that can be easily understood by the community. Organizations should participate in efforts that raise public awareness of cultural competency activities and document the progress that is being made in meeting goals,<sup>46,47</sup> which can include, for example, producing a statistical annual report on patient demographics, interpreter use, and availability; making translated materials available; and documenting progress being made in cultural competency training. Such reports also could include patient evaluations of services and providers. These approaches can serve as marketing tools, while also enhancing an organization's image among diverse communities.

## DOMAIN 3

**Patient-Provider Communication.** Clear communication at all levels and at all times among patients, clinicians, and support staff is essential for effective and culturally competent care.

### Subdomain 3.1

**Language Access.** Language access services are imperative to increase access to care; improve quality of care, patient satisfaction, health outcomes, and health status; and enhance or ensure appropriate resource utilization.<sup>48</sup> High-quality language access services are needed at all points of patient contact to improve provider and staff communication with LEP patients. Communication that

is accurate and understandable increases the likelihood of the provision of appropriate care, as well as patient safety and patient adherence.<sup>49,50,51</sup>

### Subdomain 3.2

**Interpreter Services.** High-quality interpreter services are imperative for patients to increase the likelihood that they receive appropriate care.<sup>52,53,54,55</sup> An organization should first strive to employ bilingual staff and providers. The bilingual proficiency of staff and providers needs to be assessed, however, to ensure that they speak the additional language(s) at a level such that high-quality services can be provided.<sup>56</sup> Having certified interpreters<sup>v,57</sup> available for every point of contact may not be an achievable goal, but, at minimum, professionally trained and competent interpreters should be employed "whose sole function in the healthcare setting is to interpret,"<sup>58</sup> because they clearly have been shown to be effective compared with ad hoc interpreters.<sup>59,60,61</sup> Professional interpreter services may be in person or remote; remote interpreter services include telephone language lines, video links, and other remote systems. Health professionals and other staff members need to be trained on how to work with interpreter services and how to determine whether an individual is competent to interpret.

### Subdomain 3.3

**Translation Services.** Patient-related written materials should be translated into the most common languages of the patient population<sup>62,63</sup> and should be evaluated for context, be written from the patient's perspective, and, when possible, be originally written in the intended language. Relevant patient-related materials include applications, consent forms

<sup>v</sup> When evaluating the quality of interpreter services, it is important to consider that the work of the National Coalition for Healthcare Interpreter Certification is still ongoing, and a process for certification for all languages has not yet been established.

(procedural consent, research consent), participation in therapeutic trial forms, preventive and treatment instructions, and patient education materials. Translated materials should be evaluated for linguistic and cultural appropriateness with respect to both content and context.<sup>64</sup>

### **Subdomain 3.4**

**Health Literacy Strategies.** Addressing the literacy needs of patients using both oral and written communication can be an issue even if the patient’s primary written and spoken language<sup>vi</sup> is English. *Healthy People 2010* defines health literacy as the “degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.”<sup>65</sup> People with low health literacy tend to have more problems with both written and oral communication.<sup>66</sup> Strategies to improve oral and written communication with low-literacy patients could include the following: 1) avoid the use of medical jargon, and instead use commonly understood words; 2) use audiovisual and graphic aids to supplement oral and written instructions; 3) include interactive instructions by making patients do, write, say, or show something to demonstrate their understanding; 4) write materials at or below the 5th-grade level; 5) pretest materials to evaluate whether they are suitable for the intended audience; and 6) utilize the NQF-endorsed safe practice “teach back” method to ask each patient to teach back in her or his own words key information about the proposed treatments or procedures for which he or she is being asked to provide informed consent.<sup>67,68,69</sup>

### **Subdomain 3.5**

#### **Knowledge of Culture and Social Context.**

Healthcare providers should have pertinent information about the cultural groups being served with respect to traditional healing practices; health-related beliefs and cultural values; disease incidence, prevalence, and outcomes; and health disparities.<sup>70,71,72,73</sup> This should include knowledge of the sociodemographics, migration history, and other relevant socioeconomic characteristics of members of the local communities receiving care. (See also Domain 4: Care Delivery and Supporting Mechanisms, Subdomain 4.1: Clinical Encounter.)

### **Subdomain 3.6**

**Cultural Awareness.** Self-examination and the exploration of one’s own personal and organizational cultural background are essential to optimum patient-provider communication. This includes being cognizant, observant, and conscious of similarities and differences among cultural groups.<sup>74</sup> It also includes having an awareness of one’s own assumptions, biases, stereotypes, and prejudices with respect to individuals from other cultures.<sup>75,76,77</sup> (See also Domain 4: Care Delivery and Supporting Mechanisms, Subdomain 4.1: Clinical Encounter.)

### **Subdomain 3.7**

#### **Cross-Cultural Communication Skills.**

Skills that are used to obtain culturally relevant data, such as through conducting cultural assessments and culturally based physical assessments, are a necessary component of this subdomain.<sup>78,79,80,81</sup> Patient-based cross-cultural communication makes the patient a primary source of cultural knowledge and an active participant in patient-clinician discussions.<sup>82</sup> The appropriate skills are needed to

<sup>vi</sup> “Primary written and spoken language” is defined as the self-selected language the patient wants to use to communicate with her or his healthcare provider.

identify and negotiate different styles of communication, different decisionmaking preferences and family roles, and sexual and gender issues. In addition, skills are needed to identify issues involving mistrust, prejudice, and racism; religion and spirituality; disability; and sexual orientation.<sup>83</sup> Communicating effectively with different people is a process that requires trust, awareness, sensitivity, respect, and honesty.

### **Subdomain 3.8**

**Family Centeredness.** Patient-provider communication also means respecting the wishes of members of culturally diverse groups and including family members in healthcare decisionmaking.<sup>84</sup> Organizational procedures and policies should be adapted within existing privacy regulations and laws and should accommodate family-centered care as determined by the patient. (For example, patients may have difficulty explicitly “asking” a provider to include their families in decisionmaking, but their actions may signal that they desire to do so.) Understanding the role that the family plays in healthcare decisions is integral to delivering family-centered care. This includes having knowledge of culturally defined composition and roles within families and having the skills needed to communicate with family members, with attention paid to age, gender, and more. This knowledge enables caregivers to assist family members in decisionmaking, when requested; honor patient and family perspectives and choices; and ensure that patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

## **DOMAIN 4**

### **Care Delivery and Supporting Mechanisms.**

From the first encounter to the last, care delivery structures and supporting mechanisms—the delivery of care, the physical environment where it is delivered, and links to supportive

services and providers—should support the provision of culturally competent care.

### **Subdomain 4.1**

**Clinical Encounter.** Both patients and healthcare providers bring to the healthcare encounter their own cultural backgrounds, beliefs, practices, and languages—all of which can affect interactions.<sup>85</sup> In certain instances, patients and providers could have different understandings of what constitutes appropriate care and what their roles should be in the encounter. Also, the culture or beliefs of some patients may mean they are less likely to ask questions, question the provider’s care plan, or share in decisionmaking.

### **Subdomain 4.2**

**Physical Environment.** The physical environment should include culturally sensitive design, architecture, and physical environments, where the décor, artwork, posters, and literature reflect the diversity of the area being served.<sup>86</sup> The environment also should include appropriate signage in the major languages spoken.<sup>87</sup>

### **Subdomain 4.3**

**Assessment Tools.** Tools, such as environmental scans, help elicit culturally relevant information on health beliefs, values, behaviors, and practices.<sup>88</sup> These data can be used to assist with establishing a physical environment, care delivery, and supporting mechanisms that are culturally appropriate for the community served.

### **Subdomain 4.4**

**Coordination of Care.** Documenting and tracking referrals to other healthcare services across the continuum of care and ensuring that information about patients’ cultural needs is shared with other healthcare providers are important components of delivering culturally competent care. Coordination of care also includes providing assistance with palliative



and end-of-life care and helping patients navigate the healthcare system. Care transitions back to home and family, disease management, and medication reconciliation are critical areas that require culturally competent coordination of care.

### **Subdomain 4.5**

**Linkages with Community- and Faith-Based Organizations.** Understanding and addressing the context of the patient (e.g., SES, supports/stressors, environmental hazards) are essential elements of cultural competency.<sup>89,90</sup> It also is important to identify community- and faith-based organizations, such as human, social service advocacy, civic, neighborhood, and religious organizations, and coordinate with them to assist with care delivery.

### **Subdomain 4.6**

**Linkages with Alternative Medicine Providers.** Creating these linkages involves identifying patients' use of alternative providers and complementary and integrative healing modalities. It also involves coordinating with these providers to augment allopathic treatments and avoid any complications that may result from the use of incompatible therapies.<sup>91</sup>

### **Subdomain 4.7**

**Health Information Technology.** New information technologies, such as electronic and personal medical records, should be used to enhance and promote the delivery of culturally competent care.

## **DOMAIN 5**

**Workforce Diversity and Training.** Ensuring workforce diversity and training is a way to provide more effective services for culturally diverse populations through proactive recruitment, retention, and promotion strategies. Diversity at all levels of the organization is

important. Training and development activities should include state-of-the-art content in cultural competency and should reflect organizational commitment to cultural competency.<sup>92</sup>

### **Subdomain 5.1**

**Recruitment and Retention.** Human resource practices should be aimed at diversifying the workforce at all levels of the organization.<sup>93</sup> Racial/ethnic and language concordance between patient and provider has been associated with better patient experiences with care and satisfaction.<sup>94,95</sup> However, the current demographics of the health professions do not correspond to the composition of the general workforce. For example, although African Americans and Hispanics account for about 25 percent of the workforce, fewer than 12 percent of physicians and therapists and only 15 percent of registered nurses are from these two racial/ethnic groups.<sup>96</sup> Needed are proactive recruitment strategies that will result in a more diverse applicant pool. Organizations should seek alternatives to generic newspaper advertisements, search firms, and other conventional and mainstream recruiting methods. Community-based and national organizations and networks and publications and/or search firms that target diverse populations may provide better channels for recruiting and for advertising vacancies.<sup>97</sup> Historically Black Colleges and Universities, predominately Hispanic/Latino colleges and universities, and healthcare associations representing diverse individuals are also valuable resources.

Furthermore, organizational efforts aimed at improving the diversity of the workforce pipeline are needed. This may include partnerships with local elementary and secondary schools, particularly those with a high percentage of racial/ethnic minorities, to increase students' interest in the healthcare professions. Organizational efforts need to go beyond recruitment strategies and include retention strategies—otherwise organizations can become

a “revolving door” for diverse employees, as they leave the organization in pursuit of better opportunities or a more welcoming environment. Retention strategies include efforts to create a welcoming climate for diverse populations, identify barriers that prevent employees from achieving their full potential, and provide promotion opportunities.<sup>98,99</sup> Programs for formal mentoring, leadership development, professional development and training, work-life balance and flexible benefits, and affinity groups are among the human resource retention strategies that can be used.<sup>100</sup>

### **Subdomain 5.2**

**Training Commitment and Content.** Ensuring that managers and staff at all levels of an organization receive appropriate and ongoing training in cultural competency is essential—and these efforts must be evaluated.<sup>101,102</sup>

Training should include strategies to assist diverse staff members improve how they relate to one another. Staff training should emphasize the knowledge and skills outlined under the patient-provider communication and care delivery and supporting mechanism domains.<sup>103,104</sup> Leadership training should include content from all seven of the NQF-endorsed domains of cultural competency. Cultural competency training can be delivered as a stand-alone program, or it can be integrated into other training programs. Formal training can be complemented with less formal activities that develop staff knowledge about the cultures and languages of their patients, such as cultural fairs and reading clubs focused on specific cultures or languages.<sup>105</sup> This training should be conducted by qualified staff who are trained and expert in cultural competency, and the training should be periodically updated, repeated, and assessed for effectiveness and relevance, so that it reflects the populations served by the organization and its staff.

## **DOMAIN 6**

**Community Engagement.** Active outreach and the exchange of information, as well as community inclusion and partnership in organizational decisionmaking, help ensure the provision of culturally competent care.

### **Subdomain 6.1**

**Community Outreach.** Engaging with communities means conducting active outreach that includes collaborative relationships and partnerships with entities to help understand and address the cultural needs of the communities served.<sup>106</sup> It also may include liaisons with others in the community through community health workers or by having members of minority communities reach out to their communities.<sup>107,108</sup> For example, community health workers who are trained to teach others with the same chronic conditions about disease self-management can be important resources.

### **Subdomain 6.2**

**Community Representation in Organizational Decisionmaking.** The use of formal and informal mechanisms for community engagement, such as community advisory groups or committees for service planning and implementation, helps ensure community representation in organizational decisionmaking.<sup>109,110</sup> Such mechanisms also are important to incorporate community involvement into quality improvement activities.<sup>111</sup>

### **Subdomain 6.3**

**Community Investments.** Community investment involves investing in both the infrastructure and human capital of communities, as well as taking advantage of other community assets for outreach and educational and information-gathering activities.

## Subdomain 6.4

**Community-Based Participatory Research (CBPR).**<sup>vii</sup> Actively engaging in CBPR can bring tremendous benefits. Trained community advocates can educate and inform the community about clinical trials and the need for diversity. To establish trust, the community and community advocates should be engaged before research is proposed and developed. Community advocates should be engaged, when possible, in identifying the relevance of research for members of the community and in its design and planning, and should provide feedback on how to meet community members' needs.

## DOMAIN 7

**Data Collection, Public Accountability, and Quality Improvement.** Organizations use these methodologies to collect the data needed to assess their cultural competency, to assess whether they perform routine self-assessments in this regard, and to assess whether they integrate cultural competency into their public accountability and quality improvement activities.

### Subdomain 7.1

**Collection of Patient Cultural Competency-Related Information.** Various mechanisms are used to collect data on cultural subgroups—such as race/ethnicity; country of origin; length of stay in the United States; and language preferences, education, and income of patients—and to integrate the data into information systems.<sup>112,113</sup> These data are important for strategic and service planning and can be used to monitor healthcare disparities and for

quality improvement.<sup>114</sup> The Joint Commission now requires the recording of patients' language and communication needs in the patient record.<sup>115</sup> Although this information is imperative to quality improvement, it also should be integrated into public reporting initiatives.

### Subdomain 7.2

**Collection of Community Cultural Competency-Related Information.** Collection of this information includes maintaining current demographic, cultural, socioeconomic, and epidemiological profiles and needs assessments of the communities served and using the data for strategic planning, quality improvement, and public reporting initiatives.<sup>116,117,118</sup>

### Subdomain 7.3

**Quality Improvement.** Organizations integrate cultural competency into their internal quality improvement activities. Quality improvement can be viewed as an organization-wide approach to the planning and implementation of continuous improvement in performance. As such, quality improvement emphasizes continuous internal examination and improvement of work processes by teams of staff trained in basic statistical techniques and problem-solving tools and empowered to make decisions based on the analysis of the data.<sup>119</sup> Healthcare organizations should use quality improvement activities to address health disparities in access, outcomes, or patient experiences with care.

### Subdomain 7.4

**Accountability.** Information about cultural competency and healthcare quality is imperative to help make the healthcare system more

vii Community-based participatory research (CBPR) is a collaborative approach to research that combines methods of inquiry with community capacity-building strategies to bridge the gap between knowledge produced through research and what is practiced in communities to improve health. Interest is growing rapidly among academic institutions, health agencies, and communities in forming research partnerships; however, few guidelines are available that describe how to develop or evaluate CBPR proposals or what resources are required to promote successful collaborative research efforts. See Viswanathan M, Ammerman A, Eng E, et al., *Community-Based Participatory Research: Assessing the Evidence. Evidence Report, Technology Assessment No. 99*, Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2004. AHRQ Publication 04-E022-2.

accountable, to improve patient and family understanding and decisionmaking, and to improve quality. Public reporting of quality data is widespread<sup>120,121</sup> and will continue to increase, as will pay-for-reporting and pay-for-performance initiatives by the federal government, states, and private payers. However, the degree to which patients and families are actually using this information to make decisions about their healthcare is mixed.<sup>122,123,124</sup>

### **Subdomain 7.5**

**Assessment of Patient Experiences with Care.** Patient experiences with care should be assessed in a patient's own language using qualitative and quantitative methods; this information should be reported publicly using the NQF-endorsed Hospital Consumer Assessment of Health Plans (HCAHPS), Ambulatory CAHPS (ACAHPS), and End-Stage Renal Disease CAHPS. Patient assessments of care are critical, because they capture first-hand experiences as patients interact with the healthcare system. The CAHPS® family is a set of standardized survey instruments that assess patient experiences with care in various provider settings. Earlier research using CAHPS data documents racial/ethnic and language differences in patients' experiences with care.<sup>125,126,127</sup> Focus groups and personal interviews are qualitative methods that can complement such quantitative assessments by providing more in-depth information on the observed cultural differences in patient experiences with care.

### **Subdomain 7.6**

**Performance Management Systems.** Cultural competency-related measures, such as balanced score cards, organizational climate surveys, adverse events reports, and outcome-based evaluations, should be included in organizational performance management systems.<sup>128,129</sup> Including these measures in performance management systems elevates their importance in the organization.<sup>130</sup> Examples of metrics that

can be incorporated are patient and human resource outcomes for different cultural groups.

### **Subdomain 7.7**

**Self-Assessments of Cultural Competency.** Ongoing self-assessments of an organization's progress in meeting its own cultural competency strategic plan<sup>131</sup> are needed at all four levels of care: system, organization, group, and individual.<sup>132</sup> System- and organization-level assessments provide a picture of the organization's readiness for cultural competency by examining its structures, policies, and practices. Individual-level assessments of cultural competency should be used, as should group-level assessments, which can provide a gauge of organizational culture and climate. Community assessments can provide information that can help organizations adapt to the diversity and cultural contexts of the individuals and communities served.<sup>133</sup>

### **Subdomain 7.8**

**Documentation of Cultural Competency Practices.** Mechanisms should be used to document that culturally competent care services have been delivered, such as the provision of language services, the presence of workforce diversity, the provision of referrals to alternative medicine providers and community-based organizations, and compliance with NQF-endorsed preferred practices. This information is important for ongoing self-assessments of cultural competency, as well as for public reporting of such activities.

### **Subdomain 7.9**

**Documentation of Cross-Cultural Complaints and Resolutions.** Having mechanisms in place to identify, document, and resolve cross-cultural conflicts or complaints by patients is important in the provision of culturally competent care.<sup>134</sup> Individuals from diverse backgrounds are more vulnerable to having experiences during which their cultural differences are not accommodated or respected by healthcare organizations. Some of the mechanisms that organizations can adopt to identify, document, and resolve

cross-cultural conflicts include providing cultural competency training to staff who handle complaints and grievances or other legal or ethical conflict issues; providing notice in other languages about the right of each patient to file a complaint or grievance; providing the contact name and number of the individual responsible for the disposition of a grievance; and offering ombudsperson services.<sup>135</sup>

## Preferred Practices for Measuring and Reporting Cultural Competency

### Introduction

The need for preferred practices in cultural competency for measurement and reporting is urgent. Many organizations and government agencies are currently working to advance the field and assist healthcare providers with providing culturally competent care. However, there is no consensus regarding the following central questions: 1) What constitutes culturally competent care? 2) Who is accountable to ensure it is delivered? 3) How do health systems and providers measure cultural competency? and 4) Does culturally competent healthcare lead to improved health outcomes? Without national voluntary consensus standards for culturally competent care, the important work that is currently being conducted will remain unconnected. To push the field forward, all stakeholders must rally around common preferred practices. Nationally endorsed consensus standards for culturally appropriate care can serve as a road map for the identification of a set of preferred practices and performance measures and can be used to help identify areas requiring additional research or

development. In addition, the practices will provide a structured perspective for evaluating the development, expansion, and modifications of new and existing programs (and their assessments) for cultural competency.

Cultural competency should occur across the full spectrum of healthcare delivery and should involve multiple providers, organizational staff—including leadership—and all settings of care. The purpose of preferred practices for, and ultimately, measures of, cultural competency are to:

- improve the quality of care through cultural competency and therefore achieve positive patient outcomes through care that is safe, patient and family centered, evidence based, and equitable;
- provide guidance for all stakeholders by identifying the domains and subdomains that can be used in making decisions about the delivery of culturally competent care; and
- serve as the basis for quality measures, or the development of quality measures, that can be used for public accountability.

Because measures do not exist to address comprehensive cultural competency, the NQF set of evidence-based preferred practices can serve as the building blocks for promoting high-quality, culturally competent care across all practice settings and can serve as the basis for developing performance measures.

NQF has endorsed a set of 45 preferred practices that are suitable for implementation and that address the framework domains and subdomains. Many of these practices are based on published studies, or widely accepted experiential or consensus information. Some of the subdomains included in the framework do not have endorsed preferred practices; however, this does not mean that the subdomain is

not considered to be a critical component of the framework. The preferred practices for this project were evaluated for their adequacy using NQF-endorsed standard evaluation criteria for all practice evaluations (see Box A):

*effectiveness* – clear evidence must be presented that indicates the practice would be effective in improving outcomes;

*generalizability* – the practice should be able to be utilized in multiple care settings and/or for multiple types of patients;

*benefit* – it must be clear how the practice would improve or increase the likelihood of improving patient outcomes; and

*readiness* – the training, technology, and staff required for implementation of the practice are available.

Table 1 beginning on page 17, presents the 45 preferred practices and their specifications cross-walked to the framework.

## Box A: Criteria for Evaluation of Practices

### **Evidence of Effectiveness**

There must be clear evidence that the practice (if appropriately implemented) would be effective in improving outcomes (e.g., reduced substance use). Evidence may take various forms, including:

- research studies (syntheses) showing a direct connection between the practice and improved clinical outcomes;
- experiential data (including broad expert agreement, widespread opinion, or professional consensus) showing the practice is “obviously beneficial” or self-evident (i.e., the practice absolutely forces an improvement to occur) or organization or program data linking the practice to improved outcomes; or
- research findings or experiential data from other healthcare or non-healthcare settings that should be substantially transferable.

### **Generalizability**

The practice must be able to be utilized in multiple applicable clinical care settings (e.g., a variety of inpatient and/or outpatient settings) and/or for multiple types of patients.

### **Benefit**

If the practice (determined to be effective) were more widely utilized, it would improve or increase the likelihood of improving patient outcomes (e.g., improved patient function). If an effective practice already is in near universal use, its endorsement would lead to little new benefit to patients.

### **Readiness**

The necessary technology and appropriately skilled staff must be available to most healthcare organizations. For this project, opportunity for measurement also was a consideration.

Table 1: Preferred Practices and Specifications Cross-Walked to the Framework

DOMAIN	SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT
<b>Domain 1: Leadership</b>	Organizational Culture (1.1)	1	Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.
	Organizational Culture (1.1)	2	Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.
	Commitment to Serving a Diverse Population (1.2)	3	Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.
	Leadership Diversity (1.3)	4	Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.
	Dedicated Staff and Resources (1.4)	5	Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.
	Policies (1.5)	6	Commit to cultural competency through systemwide approaches that are articulated through written policies, practices, procedures, and programs.
	Training and Development (1.6)	7	Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

more

Table 1: Preferred Practices and Specifications Cross-Walked to the Framework

DOMAIN	SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT
<b>Domain 2: Integration into Management Systems and Operations</b>	Strategic Planning (2.1)	8	Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.
	Service Planning (2.2)	9	Implement language access planning in any area where care is delivered.
	Reward Systems (2.4)	10	Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.
	Marketing and Public Relations (2.5)	11	Market culturally competent services to the community to ensure that communities that need services receive the information.
<b>Domain 3: Patient-Provider Communication</b>	Language Access (3.1)	12	Offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
	Language Access (3.1)	13	Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.
	Interpreter Services (3.2)	14	Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.

more



Table 1: Preferred Practices and Specifications Cross-Walked to the Framework

DOMAIN	SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT
<b>Domain 3: Patient-Provider Communication</b> <i>(continued)</i>	Translation Services (3.3)	15	Translate all vital documents, at a minimum, into the identified threshold languages for the community that is eligible to be served.
	Translation Services (3.3)	16	Translate written materials that are not considered vital when it is determined that a printed translation is needed for effective communication.
	Translation Services (3.3)	17	Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document.
	Health Literacy Strategies (3.4)	18	Use “teach back” as a patient engagement tool to enhance communication between the healthcare provider and the patient during clinical encounters.
	Health Literacy Strategies (3.4)	19	Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.
	Cultural Awareness (3.6)	20	Regularly assess attitudes, practices, policies, and structures of all staff as a necessary, effective, and systematic way to plan for and incorporate cultural competency within an organization.
	Family Centeredness (3.8)	21	Include family members in healthcare decisions, when requested by the patient, when providing care for culturally diverse populations.

more

Table 1: Preferred Practices and Specifications Cross-Walked to the Framework

DOMAIN	SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT
<b>Domain 4: Care Delivery and Supporting Mechanisms</b>	Clinical Encounter (4.1)	22	If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.
	Clinical Encounter (4.1)	23	Develop and implement a comprehensive care plan that addresses cultural concerns.
	Clinical Encounter (4.1)	24	Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.
	Physical Environment (4.2)	25	Adapt the physical environment where the healthcare is being delivered to represent the culture of the populations who access their healthcare in that environment.
	Coordination of Care (4.4)	26	Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.
	Health Information Technology (4.7)	27	Explore, evaluate, and consider the use of multimedia approaches and health information technology to enable the provision of healthcare services that are patient and family centered and culturally tailored to the patient.
<b>Domain 5: Workforce Diversity and Training</b>	Recruitment and Retention (5.1)	28	Recruit and hire ethnically diverse providers and staff at all levels, including management levels.
	Recruitment and Retention (5.1)	29	Actively promote the retention of a culturally diverse workforce through organizational policies and programs.
	Training Commitment and Content (5.2)	30	Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.

more

Table 1: Preferred Practices and Specifications Cross-Walked to the Framework

DOMAIN	SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT
<b>Domain 6: Community Engagement</b>	Community Outreach (6.1)	31	Engage communities to ensure that healthcare providers (individual and organizational) are aware of current and changing patient populations and cultural and communication needs and provide opportunities to share resources and information.
	Community Outreach (6.1)	32	Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.
	Community Outreach (6.1)	33	Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating the effectiveness of cultural competency activities.
	Community Investments (6.3)	34	Healthcare professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.
	Community-Based Participatory Research (6.4)	35	Use the methodology of community-based participatory research when conducting research in the community as a collaborative approach to research that equitably involves all stakeholders in the research process and fosters the unique strengths that the community brings to the process.

more

Table 1: Preferred Practices and Specifications Cross-Walked to the Framework

DOMAIN	SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT
<b>Domain 7: Data Collection, Public Accountability, and Quality Improvement</b>	Collection of Patient Cultural Competency-Related Information (7.1)	36	Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner.
	Collection of Patient Cultural Competency-Related Information (7.1)	37	Ensure that, at minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.
	Collection of Community Cultural Competency-Related Information (7.2)	38	Utilize indirect data collection methodologies (e.g., geocoding, surname analysis) to characterize the race, ethnicity, and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.
	Collection of Community Cultural Competency-Related Information (7.2)	39	Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.
	Quality Improvement (7.3)	40	Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.
	Accountability (7.4)	41	Publicly report data for the applicable NQF-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care stratified by race/ethnicity and primary written and spoken language.

more

Table 1: Preferred Practices and Specifications Cross-Walked to the Framework

DOMAIN	SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT
<b>Domain 7: Data Collection, Public Accountability, and Quality Improvement</b> <i>(continued)</i>	Accountability (7.4)	42	Regularly make available to the public information about progress and successful innovations in implementing culturally competent programs (especially the NQF-endorsed preferred practices for cultural competency), and provide public notice in communities about the availability of this information.
	Assessment of Patient Experiences with Care (7.5)	43	Assess and improve patient- and family-centered communication on an ongoing basis.
	Assessment of Patient Experiences with Care (7.5)	44	Any surveys created by or conducted by the organization must collect race, ethnicity, and primary written and spoken language, and analysis and results must be stratified by race, ethnicity, and primary written and spoken language.
	Documentation of Cross-Cultural Complaints and Resolutions (7.9)	45	Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.

## Domain 1: Leadership

### The Problem

The U.S. population continues to grow and rapidly diversify among racial and ethnic groups.<sup>136</sup> It is projected that by the year 2050, Hispanics and foreign-born residents will make up 48 percent of the U.S. population.<sup>137</sup> This large shift in demographics will require changes within the healthcare system to adjust the delivery of care for these increasingly diverse populations. Culturally competent care will become an increasingly important component of the provision of healthcare services. Culturally competent care directly affects how care is delivered and received.<sup>138</sup> Without it, care is not patient centered and is likely to be inequitable.

It has become increasingly more difficult for people to navigate and adapt to a healthcare system that is not tailored to their needs. Different patients speak different languages and have different concepts about healthcare, including beliefs and practices about disease and treatments. Although this may present a challenge to healthcare professionals who have been trained in the concepts of Western medicine, the burden of navigating the complexities of healthcare should not fall solely on the patient.<sup>139</sup>

Sociocultural differences among patients, healthcare providers, and the healthcare system can be viewed by healthcare experts as potential causes for disparities. These include variations in patients' abilities to recognize clinical symptoms of disease and illness, different thresholds for seeking care, differing expectations of care, and differences

in understanding prescribed treatments and the decisions to follow those treatments.<sup>140</sup>

Differences between the patient and provider also can influence providers' decisionmaking and interactions between patients and the healthcare delivery system.<sup>141</sup> Furthermore, a patient's satisfaction with care directly affects his or her adherence to therapy and continuity of care.<sup>142</sup>

Like general quality improvement or improving patient safety, quality improvement for cultural competency directly stems from the leadership and culture of a healthcare organization. Healthcare providers, clinical, and organizational leaders, governance boards, CEOs, and the community play an essential role in developing and implementing cultural competency initiatives, setting organizational policy and strategy, and monitoring organizational performance.

Leadership is multifaceted and should include an organizational culture that is committed to diversity and that has sufficient staff and resources and appropriate policies for implementation, governance, and training and development.<sup>143</sup> Studies have shown that 98 percent of senior leaders in healthcare management do not reflect the population they are serving.<sup>144</sup> This important concern can be addressed by ensuring that minority healthcare professionals are included in sufficient numbers in the healthcare workforce. In general, such professionals would be more likely than non-minority professionals to take into account a range of sociocultural factors when organizing healthcare delivery systems to meet the needs of minority populations.<sup>145</sup> Currently, community-based organizations, healthcare organizations, and healthcare professionals are beginning to

implement strategies to address racial/ethnic disparities relevant to the populations they are serving.<sup>146</sup> Most of these adjustments include those made to services and programs, but the most important factor in providing culturally appropriate care centers on the committed involvement of leaders at all levels within an organization.<sup>147</sup>

A commitment to culturally competent care can be reflected through how an organization plans its work and by its guiding principles and policies.<sup>148</sup> In addition, those who are members of an organization should reflect the populations they are serving.<sup>149</sup> Research continues to suggest that the cultural orientation of the medical care system is not sufficiently congruent with the cultural perceptions of the patients.<sup>150</sup> Leaders can improve this situation by creating an organizational culture that can serve as a model of culturally competent behavior—for example, by designating an individual responsible for managing cultural competency programs, having formal plans demonstrating how the needs of the diverse population will be met, and providing funds for initiatives.<sup>151</sup> Ultimately, culturally competent care must take a systemwide approach and incorporate the active involvement of leadership to ensure a continuing commitment to providing patient-centered, equitable care.

## Preferred Practices

### Organizational Culture (1.1)

**Preferred Practice 1:** Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.

#### Specifications:

- Leadership support should be visible.
- Standardized policies and procedures to facilitate cultural competency should:
  - 1) ensure that organizational leadership is knowledgeable about cultural competency issues present within the organization and is continuously involved in processes to assure that the issues are appropriately addressed;
  - 2) provide oversight and coordination of cultural competency activities; and
  - 3) provide feedback to frontline healthcare providers about lessons learned.
- Leadership should ensure that all staff are trained in techniques of teamwork-based problem solving and management.
- Leadership structures and systems should ensure organization-wide awareness of
  - 1) performance gaps (and they should promote the direct accountability of leaders for those gaps) and
  - 2) performance assets that can benefit through dissemination and diffusion throughout the organization.
- Leadership should both communicate and demonstrate through their personal behavior that diversity and serving diversity well are two of the values of the organization.
- Governance boards and senior administrative leaders should be briefed regularly regarding the organization's cultural competency practices to understand how tightly linked they are with providing quality care and how the activities overlap.

- Governance boards and senior administrative leaders should become personally involved in patient safety to comply with the practices that will constitute the first step to transforming the culture of the organization.

**Preferred Practice 2:** Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.

**Specifications:**

- Focus on midlevel manager champions who recognize a need, hold enough power to encourage change, and are capable of building support.
- Establish champions at multiple levels of the organization.
- Ensure that leadership support of the champions is visible.
- Integrate interpreters and community outreach workers on committees throughout the organization.
- Integrate cultural competency as a component of performance evaluations; demonstrate technical skills, the ability to meet organizational standards, and a commitment to understanding patients' cultures and improving communication skills.
- Integrate cultural competency within the larger measurement framework of the organization in order to reduce disparities and increase the capacity of the organization to provide culturally competent care.
- Ensure that leaders directly address the need to improve communication about cultural competency through initiatives, policies, and presentations and that leaders are integrated into ongoing projects.

**Commitment to Serving a Diverse Population (1.2)**

**Preferred Practice 3:** Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.

**Specifications:**

- Make publicly available the vision, goals, and mission of the organization and the action plan for implementation, after ensuring that staff members have had the opportunity to provide input and comment.
- Update the action plan at least annually.

**Leadership Diversity (1.3)**

**Preferred Practice 4:** Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.

**Specifications:**

- Establish an internal mechanism for developing strategies that involve using a committee of current diverse staff for recruitment, retention, and promotion.
- Conduct internal and external assessments on how to address the need for staff diversity.
- Engage with community leaders, and specifically target and recruit from the community served.
- Ensure that recruitment and selection processes focus on meeting the needs of the organization's goals for culturally competent care.



### **Dedicated Staff and Resources (1.4)**

**Preferred Practice 5:** Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.

#### **Specifications:**

- Leaders must consult with the care setting managers, clinical leaders, language service providers, and others to identify needed fiscal and human resources to appropriately meet the cultural needs of patients. The demographic profile (see Domain 7) may help inform this process.
- Leadership should provide staff, at all levels, with the available time and resources for training programs and practices that promote culturally competent care.
- Ensure that continued training and coaching on culturally competent care is available for new and current staff.
- Document where the fiscal support for these activities is within the organization.
- Ensure that there are budget line items and specific allocations for cultural competency activities and programs.
- Establish and enforce organizational policies that support the allocation of fiscal resources for cultural competency.

### **Policies (1.5)**

**Preferred Practice 6:** Commit to cultural competency through systemwide approaches that are articulated through written policies, practices, procedures, and programs.

#### **Specifications:**

- Establish a committee or another body (or utilize an existing one) to ensure that cultural competency is integrated systemwide; the committee or body should be composed of leaders and should report directly to the governance board and other leaders.
- Leadership should develop and/or provide the necessary professional development training to staff, including all managers, who will be accountable to the public in matters regarding legal compliance and accreditation requirements and for the organization's policy on cultural competency.
- Leadership should ensure that cultural competency policies are, with proper guidance, consistently administered and implemented across the departments.
- Leadership should involve diverse sectors of the community in the planning, ongoing feedback, and evaluation of programs and services.
- An evaluation system should be implemented to monitor and provide ongoing feedback on the effectiveness of diversity and cultural competency programs and strategies, including employee training sessions.
- An advisory body of stakeholders should be appointed and should meet quarterly to facilitate community input and support in implementing and evaluating cultural competency standards.
- Information should be disseminated continuously to all facilities and programs on updated regulatory policies, regulations, and accreditation guidelines related to requirements involving cultural matters.

### **Training and Development (1.6)**

**Preferred Practice 7:** Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

#### **Specifications:**

- Training and development could include the following content:
  - in-depth knowledge of the causes and research surrounding cultural competency, inequities and healthcare disparities, and the understanding of different cultural beliefs and attitudes related to healthcare and treatment for predominant populations served by the organization;
  - quality improvement strategies and skills to address disparities;
  - leadership skills to implement solutions and help transform organizations;
  - strategies to improve the cultural competency of the organization;
  - knowledge on the linkage between cultural care; improved health outcomes, legal requirements and policies, including local, state, and federal standards; quality of care issues; the importance of the skilled use of qualified interpreters; and information about the programs and services offered; and
  - knowledge of the cultural and linguistic access policies of the organization, including how to obtain language assistance services.
- Management should develop and provide training opportunities on diversity and cultural competency for staff and senior management, as well as for physicians, nurses, allied professionals, and other clinicians and providers.

## **Domain 2: Integration into Management Systems and Operations**

### **The Problem**

Providing culturally competent care depends largely on the willingness of organizations to learn, adapt, and incorporate explicit strategies into their guiding missions and goals.<sup>152</sup> Appropriately addressing the healthcare needs of diverse populations involves an organization's total commitment; culturally appropriate services must be integrated to ensure that supportive infrastructure is in place for implementation.<sup>153</sup> Without an organizational commitment to cultural competency and a plan of action, initiatives often can be overlooked by other organizational priorities.<sup>154</sup> Integrating culturally competent care into management systems involves strategic planning, service planning, and marketing, in addition to using continuous improvement systems for staff that include performance evaluations and reward systems.

Strategic planning helps an organization define its structural activities, develop policies, and set goals relevant to culturally appropriate services.<sup>155</sup> A key component for planning is leadership support, which serves to recognize, prioritize, and drive many of the needed efforts.<sup>156</sup> Most healthcare systems and structural processes are shaped and defined by leadership; with adequate management systems, services continue to flourish, and commitment from all staff members is achievable.<sup>157</sup> Strategic planning ultimately helps a healthcare organization identify, monitor, and evaluate system features that may require the implementation of new policies or programs to stay

consistent with the organization's overall mission.<sup>158</sup>

The planning of services is closely integrated with strategic planning. Designing services that meet the needs of a diverse patient population is vitally important and should cover all elements involved in healthcare encounters. Examples include ensuring that accurate communication occurs between the patient and provider, that the provider adapts services to accommodate religious or dietary preferences, and that clinic hours are expanded to accommodate a range of schedules.<sup>159</sup> Specific services should be planned for diverse communities, and appropriate marketing strategies should be implemented. Marketing services to the community should encompass a broad array of outlets, such as ethnic newspapers, common gathering areas, such as churches, and television/radio advertising. A targeted approach helps to ensure that information is available to those who need healthcare services and creates opportunities for providers, patients, and the general community to work together to improve the care provided.

A separate but equally important aspect to the integration of culturally competent services is sustainable support from staff. This can be achieved through many avenues, including the use of performance evaluations and reward systems. Evaluation systems are essential for achieving accountability, identifying problems, and developing an approach for making improvements. Audits are also used at some organizations to determine whether the core structure of the workforce is knowledgeable and represents the needs of diverse communities.<sup>160</sup> One management tool that is widely recognized is incentivizing behavior. Rigorous

award programs such as the Malcolm Baldrige National Quality Award or the NCQA Recognizing Innovation in Multicultural Health Care award program require the submission of evidence of impact as part of the application. These programs require the applicant to measure and evaluate its program and that the program demonstrates improvement. Striving to be recognized by an award program arguably could be considered to drive improvement.

Organizational policies and procedures can provide a supportive base for meeting the needs of diverse populations. A supportive infrastructure is the first and most important step needed to integrate cultural competency into management systems and operations.<sup>161</sup>

## Preferred Practices

### *Strategic Planning (2.1)*

**Preferred Practice 8:** Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services. (This preferred practice also relates to the Leadership subdomains of Policies and Commitment to Serving a Diverse Population and the Data Collection, Public Accountability, and Quality Improvement subdomains of Accountability and Performance Management Systems.)

#### **Specifications:**

- A strategic plan should be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected.
- Any results from data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

### **Service Planning (2.2)**

**Preferred Practice 9:** Implement language access planning in any area where care is delivered.

#### **Specifications:**

- A language services coordinator should be a staff member who is designated to coordinate all language service activities, and this coordinator should be familiar with the service needs of the LEP population, the resources available in the community, and potential partners and funding sources for meeting the identified needs.
- Written language plans should be developed that identify language needs and set forth the organization's strategy for meeting those needs. Having such a plan also is evidence of a provider's compliance with Title VI.<sup>viii,162</sup>
- A language service delivery plan should be developed. The manual should include, but not be limited to, copies of staff interpreter job descriptions, language service protocols, training modules for bilingual staff, translations of vital documents, and signage.

### **Reward Systems (2.4)**

**Preferred Practice 10:** Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.

#### **Specifications:**

- Establish standardized evaluation criteria to assess individuals, initiatives, and programs on equal par with other recognition activities and awards.
- Reward individuals, initiatives, or programs that improve cultural competency and reduce health disparities or that go beyond the preferred practices in this document.

<sup>viii</sup> Title VI mandates that health and human service providers ensure that those with LEP can meaningfully access programs and services and a variety of additional sources, including federal and state laws and regulations, managed care contracts, and healthcare accreditation organizations.

### **Marketing and Public Relations (2.5)**

**Preferred Practice 11:** Market culturally competent services to the community to ensure that communities that need services receive the information.

#### **Specifications:**

- Identify a staff member who is responsible for facilitating communication with communities about culturally competent services.
- Use social marketing campaigns to ensure that the community is aware of the health-care disparities in the area and how the organization or provider addresses those disparities.

## **Domain 3: Patient-Provider Communication**

### **The Problem**

There is a mounting barrier to healthcare quality—problems involving communication between providers and patients. Even when the provider and the patient speak the same language, their communication is generally not optimal, and the patient's understanding of the interaction is lacking.<sup>163</sup> Today, approximately 49.6 million Americans speak a language other than English at home, and 23.3 million have LEP.<sup>164</sup> With the growing diversity of the U.S. population, a dialogue on healthcare becomes more difficult. Clear patient-provider communication is essential for effective care and directly affects the quality of care that is provided, including recovery time and adherence.<sup>165</sup>

Communication is both verbal and nonverbal and includes language access, interpreter services, written communication, and body language. It also involves personal characteristics, social attitudes and values, race, ethnicity, sexual orientation, age, gender, education, and physical and mental health.<sup>166</sup> More effective patient-provider communication can lead to better self-care behavior as well as improvements in health outcomes.<sup>167</sup>

When it comes to receiving healthcare, language barriers often are considered to be as significant as the barriers presented by the lack of health insurance.<sup>168</sup> Language barriers manifest not only through spoken language, but also through interpreters, translation services, health literacy strategies, cultural awareness, and cross-cultural communication skills. Additionally, health status is influenced not only by individual attributes such as genetics and health behaviors, but also by the patient's culture.<sup>169</sup> Patients who face language barriers are less likely to have a usual source of preventive care, and they have an increased risk of nonadherence to medication.<sup>170</sup> Often, those who have difficulty speaking English use physician services less, and they are less likely to keep follow-up appointments.<sup>171</sup> Inadequate communication also leads to delayed care and ultimately can cost a hospital more money because of malpractice settlements.<sup>172</sup>

Legally, patients seeking services must be offered a qualified interpreter regardless of the language spoken or the cost involved, and organizations should maintain sufficient services and resources to do so. Currently, however, interpreter services are provided ad hoc in some instances, using other patients,

family members, and nonclinical personnel. These ad hoc services usually have negative consequences, such as reduced physician trust, lower patient satisfaction, inaccurate communication, breach of patient confidentiality, and inadequate diagnosis.<sup>173</sup> According to one study, interpreters were not used in 46 percent of emergency department cases involving LEP patients.<sup>174</sup> Also, even if services are available, many people in a service area, especially individuals with LEP, may be unaware of an organization's services and never utilize its programs.

Written communication serves a role that is just as important as that of verbal communication. Materials provided to patients should be translated into the common language(s) for the provider's service population. Relevant information includes applications, consent forms, preventive and treatment instructions, and patient education materials.<sup>175</sup>

Translations must be evaluated for content, as well as reading level. In one study of informed consent for surgery and other procedures, the mean educational grade level required to understand consent forms was 12.6—which is equivalent to some college education.<sup>176</sup> Even the small proportion of consent forms that are written at a lower grade level may well be inaccessible to many people. Based on the 2003 National Adult Literacy Survey, only 12 percent of adults had a proficient health literacy level. Patients' "functional health literacy,"<sup>177</sup> resulting from a lack of familiarity with healthcare terms and phrases, may be much worse than their general literacy; IOM estimates that 90 million (47 percent) of U.S. adults have limited health literacy.<sup>178</sup> Adding LEP on top of health literacy barriers

means that patients with limited literacy and LEP who undergo surgical procedures have little understanding about risks or alternative options and even less opportunity to intervene if an obvious error is about to occur.

Effective patient-provider communication also may involve integrating the family and its values in standard care. Family-centered care when healthcare decisions are made is especially important for certain cultures.<sup>179</sup> One study revealed that Korean and Mexican Americans prefer a family-centered model of care, particularly with respect to decisions about terminal conditions and treatments.<sup>180</sup> And, in some cases, family members may serve as the decisionmaker, even replacing the patient. A lack of accommodation in this regard may result in a noncompliant patient and a decrease in quality of care.<sup>181</sup>

Providers should be equipped with the knowledge, skills, and resources they need to address barriers within a culturally diverse population. There are clear benefits that accrue from cultural awareness and professional training. A pilot study of second-year medical students captured a baseline measure of cultural elicitation use by the students. A six-hour intervention followed that included an assessment of cultural beliefs and attitudes, reading and discussion, culture and its role in illness, and self-assessment exercises. Results revealed that, from baseline, all subjects increased their use of cultural elicitation after the intervention, and all subjects spent more time with their patients.<sup>182</sup>

High-quality services are needed at all points of contact with patients with LEP, not just communication between patients and

healthcare professionals.<sup>183</sup> Thoughtful and appropriate language access and adequate strategic planning will help in assessing patient language needs and will allow potential activities and costs to be analyzed and programs to be developed.<sup>184</sup>

## Preferred Practices

### Language Access (3.1)

**Preferred Practice 12:** Offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.

#### Specifications:

- Language resources encompass competent interpreters (staff, contractors from outside agencies, remote telephonic or video interpreting services, or credentialed volunteers) and/or bilingual/multilingual clinical staff for clinical encounters, as well as bilingual/multilingual general staff as navigators for other encounters (e.g., to assist in making appointments, assist with transfers within a facility).
- All staff providing interpreting services or care directly provided in another language to patients should be qualified, assessed, and monitored to determine competency to provide services in healthcare settings.
- Timely access to interpreter services is particularly critical in certain service areas such as emergency departments.
- Title VI, at a minimum, should guide language access resource policies.

- LEP individuals should be informed—in their primary language—that they have the right to free language services and that such services are readily available.
- At all points of contact, healthcare organizations should distribute written notices with this information and post translated signage that language services are available free of charge.
- Patients should be explicitly asked about their primary written and spoken language, and the information should be noted in all records; the primary language of each patient is the language he or she feels most comfortable using in a clinical or nonclinical encounter.
- Informing patients about language assistance services should include one or more of the following efforts: 1) use language identification or “I speak...” cards; 2) post and maintain signs in regularly encountered languages at all points of entry; 3) create and use uniform procedures for timely and effective telephone communication between staff and LEP patients; and 4) include statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

**Preferred Practice 13:** Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.

**Specifications:**

- Use the following questions from the Health Research & Educational Trust (HRET) toolkit:
  - 1) What language do you feel most comfortable speaking with your doctor or nurse?
  - 2) How would you rate your ability to speak

and understand English? 3) Would you like an interpreter? 4) In which language would you feel most comfortable reading medical or healthcare instructions? and 5) How satisfied are you with your ability to read English?

- Providers should take steps to introduce language access at the first points of patient contact through, for example, posters and cards used by front desk staff to identify and document patients’ language needs.
- Document the ways in which the linguistic needs of a patient or legal representative have been met by the healthcare facility or provider.
- Telephone reception issues should be addressed to help to ensure that LEP patients can effectively communicate with office staff. Generally, a bilingual staff member should answer the telephone; if not, an English-speaking staff member should immediately request assistance from a bilingual staff person or should use remote translation services.
- Ensure that answering services or telephone answering machines provide information to LEP individuals, particularly after-hours callers. This may include statements in multiple languages that inform callers how to contact emergency services.
- Create an easily accessible record of the primary language written and spoken by patients by developing a coding system that can be used for computer and chart notations.

### **Interpreter Services (3.2)**

**Preferred Practice 14:** Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.

#### **Specifications:**

- Sufficient resources encompass competent interpreters (staff, contractors from outside agencies, remote telephonic or video interpreting services, or credentialed volunteers) and/or bilingual/multilingual clinical staff for clinical encounters, as well as bilingual/multilingual general staff as navigators for other encounters (e.g., to assist in making appointments, assist with transfers within a facility).
  - All individuals providing interpreting services or providing direct care in another language should be qualified, assessed, and monitored to determine their language competency in healthcare settings.
  - All bilingual/multilingual staff and providers should be assessed and monitored to determine their competency.
  - Minors, children, family members, and friends may not be used to provide interpreting services, except in life-threatening emergencies.
  - Clinicians should receive training on how to work effectively with language services.
- Organizations should ensure that their interpreting services adhere to the National Council on Interpreting in Health Care's *National Standards of Practice for Interpreters in Health Care* and *National Code of Ethics for Interpreters in Health Care*.
  - The facility should post and maintain a sign, similar in size and legibility to the Hill-Burton Community Service notices supplied by DHHS under the provisions of 42 C.F.R. 124.604(a), informing the public of the availability of interpreter services at all points of contact.

### **Translation Services (3.3)**

**Preferred Practice 15:** Translate all vital documents, at a minimum, into the identified threshold<sup>ix</sup> languages for the community that is eligible to be served.

#### **Specifications:**

- An organization should develop a standard policy, including available resources, to ensure competent communication of vital documents that are for nonthreshold languages.
- If a vital document is not translated, a qualified interpreter should be used to translate the documents free of charge, and notice of the availability of an interpreter should be provided to LEP patients.
- Vital documents requiring translation include but are not limited to:
  - therapeutic trial consent forms;
  - signage and way-finding directions;
  - patient intake forms;

<sup>ix</sup> Title 9 of the California Code of Regulations, Section 1810.410, addresses the Cultural and Linguistic Requirements of the public mental health systems in California. Section 1810.410(f) defines threshold language as a primary language spoken by 3,000 people or 5 percent of the beneficiary population, whichever is lower in an identified geographic area. However, state requirements may vary, so be sure to follow your state's requirement.



- consent forms for, but not limited to, medical treatment, surgery, anesthesia, inpatient psychiatric treatment, diagnostic tests, and advance directives;
- patient complaint forms and grievance process forms;
- letters and notices pertaining to the reduction, denial, or termination of services or benefits;
- letters or notices that require a response from the beneficiary or client;
- documents that advise of the availability of free language assistance;
- documents that provide information on emergency health issues;
- documents that provide information about patient rights and responsibilities;
- documents that provide billing and financial information;
- documents that provide general information on current clinical trials being conducted within the facility and opportunities to participate in them;
- applications for federal/state health and social services programs, including information about the availability of financial assistance;
- consent forms for releasing medical information;
- appointment reminder notices;
- key health education materials;
- HIPAA Privacy Notices;
- discharge instructions; and
- medication instructions.

**Preferred Practice 16:** Translate written materials that are not considered vital when it is determined that a printed translation is needed for effective communication.

**Specifications:**

- Organizations should develop a standard policy to ensure competent communication and translation of documents that are not considered vital.
- At a minimum, materials such as comment and feedback cards, patient satisfaction surveys, and other materials soliciting feedback from patients and their families should be included in the policy.

**Preferred Practice 17:** Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document.

**Specifications:**

- An Interpreter Attestation Form shall be completed when an interpreter is interpreting a discussion between a patient and a physician relating to a medical procedure, particularly when that discussion is for the purpose of obtaining an informed consent for treatment, and/or for those instances when sight/oral translation of the written information contained on the informed consent form in the presence of the healthcare provider has been used. If the interpretation was done remotely, then the form should be filled out and sent electronically or faxed to the healthcare provider.
- The form shall be signed by the interpreter to verify that the information was interpreted, and it should be attached along with the consent to the medical record.

### **Health Literacy Strategies (3.4)**

**Preferred Practice 18:** Use “teach back” as a patient engagement tool to enhance communication between the healthcare provider and the patient during clinical encounters.

#### **Specifications:**

- At a minimum, patients should be able to explain, in their everyday words, the diagnosis/health problem for which they need care and instructions for the prevention and/or treatment of conditions.
- “Teach back” should begin early in the process of patient care decisionmaking to ensure that patients have time to understand and think about their care options.
- Questions that begin with phrases such as “I want to be sure we have the same understanding...,” “Please tell me in your own words...,” and “This is important for your safety...,” asked by healthcare professionals through interpreters will allow patients to relay or teach back that they understand what they have been told.
- Consider using a standardized approach to educating providers that promotes adequate communication and informed consent and one that appreciates the implications of limited health literacy.
- Use new staff orientations and ongoing educational and peer reinforcement events to teach the process of improving communication, which should include specifically telling patients that to help ensure better communication they need to state in their own words what the provider discussed with them.
- Children also should be assessed for their understanding of their condition, taking into account developmental stage.

**Preferred Practice 19:** Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.

#### **Specifications:**

- Ask each patient or legal surrogate to teach back in his or her own words key information about the proposed treatments or procedures for which he or she is being asked to provide informed consent.<sup>185</sup>
- At a minimum, patients should be able to explain, in their everyday words, the diagnosis/health problem for which they need care; the name/type/general nature of the treatment, service, or procedure, including what receiving it will entail; and the primary risks, benefits, and alternatives.
- Informed consent documents for use with a patient should be written at or below the 5th-grade level and in the primary language of the patient.
- Engage the patient, and, as appropriate, the family and other decisionmakers, in a dialogue about the nature and scope of the procedure for which consent is being sought.
- Provide a qualified medical interpreter or reader to assist patients with LEP and limited health literacy patients and patients with visual or hearing impairments.
- This practice encompasses both informed consent as well as assent by adolescent patients.
- Children also should be assessed for their understanding of their condition, taking into account developmental stage.

### **Cultural Awareness (3.6)**

**Preferred Practice 20:** Regularly assess attitudes, practices, policies, and structures of all staff as a necessary, effective, and systematic way to plan for and incorporate cultural competency within an organization.

#### **Specifications:**

- The assessment must be conducted in an environment that 1) offers participants a forum to provide honest statements regarding their level of awareness, knowledge, and skills related to cultural competency; 2) provides participants an opportunity to share their individual perspectives in a candid manner; and 3) assures that the information provided will be used to effect meaningful change within the organization.<sup>186</sup>
- The assessment must solicit and value the experiences and perspectives of patients and families who receive services.
- Results should be used to strategically plan long- and short-term objectives to enhance the organization's capacity to deliver culturally competent services by all levels within the organization, including policymakers, administrators, providers, subcontractors, and consumers, and at both the state and local levels.
- Assessment results must be shared with participants and key stakeholders in a manner that meets their unique needs.
- A quality improvement framework should be used to make improvements.

### **Family Centeredness (3.8)**

**Preferred Practice 21:** Include family members in healthcare decisions, when requested by the patient, when providing care for culturally diverse populations.

#### **Specifications:**

- Healthcare providers listen to and honor patient and family perspectives and choices.
- Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into care planning and decisionmaking.
- Healthcare providers communicate and share complete and unbiased information with patients and families in ways that are affirming, respectful, and useful.
- Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decisionmaking.
- Patients and families are encouraged and supported in participating in care and decisionmaking at the level they choose.
- Patients, families, and providers collaborate in policy and program development, implementation, and assessment; in healthcare facility design; and in professional education—as well as in the delivery of care.

## Domain 4: Care Delivery and Supporting Mechanisms

### The Problem

Many potential causes contribute to healthcare disparities and to the fact that culturally diverse patients have different levels of satisfaction with the care they receive. Recent studies, however, have indicated that variations in patients' health beliefs, values, preferences, and behaviors play an important role.<sup>187,188,189</sup>

The burden of adapting to and navigating through a healthcare environment should not be placed solely on the patient. Healthcare professionals and organizations should think proactively and incorporate initiatives and activities that address the needs of diverse populations.<sup>190</sup>

Lack of culturally competent care is not an abstract concept that affects only patient perception of care. For example, data from communities involved in the Robert Wood Johnson Foundation's initiative Expecting Success: Excellence in Cardiac Care indicate that a number of characteristics of healthcare providers may affect culturally diverse populations' access to heart healthcare and contribute to disparities. The factors are market competition; the growing trend of market segmentation; the lack of dedicated resources to provide care for the uninsured; referral arrangements; and the frequent need to coordinate cardiac care across multiple sites and providers.<sup>191</sup>

Important variations also exist in the way that diverse populations communicate with their providers, and these variations may affect

the kind of care they receive. This can include variations in patient descriptions, recognition, and communication of symptoms, variations regarding when patients seek care, and variations in the comprehension of the prescribed management strategy and adherence.<sup>192</sup> In addition, spirituality is an important factor in healthcare delivery, particularly among culturally diverse populations, yet it is often neglected.<sup>193</sup> Although up to 77 percent of patients would like spiritual/religious issues to be considered as part of their medical care, only 10 to 20 percent of caregivers discuss these issues with their patients.<sup>194</sup> Spirituality and religion often are considered a significant component of culture, and as the healthcare system incorporates changes to reflect culturally competent care, the effects of religion and spirituality on patient safety and care also should be considered.

Providing culturally competent care means properly addressing the manner in which care is delivered, the physical environment where that care is delivered, and linkages with supportive services and providers. Without a comprehensive, holistic approach, it will be difficult to eliminate the inequities in healthcare services that are provided to minority populations.

When addressing care delivery and its supporting mechanisms, it is important to promote collaboration with other industry stakeholders to share best practices, promote the use of educational materials, and coordinate outreach efforts.

## Preferred Practices

### **Clinical Encounter (4.1)**

**Preferred Practice 22:** If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.

#### **Specifications:**

- In order to be included in such a directory, providers should be assessed for language proficiency if it is not their native language.
- The directory should be easy to read and provided in an accessible format.
- The directory should be created by individuals who understand the various languages and cultures that are included.

**Preferred Practice 23:** Develop and implement a comprehensive care plan that addresses cultural concerns.

#### **Specifications:**

- The care plan should be developed with patients and their caregivers.
- The care plan should note patients' and families' primary written and spoken languages and any cultural beliefs that might affect the care plan, including but not limited to those involving spirituality/religion, nation of origin, and ethnicity.

**Preferred Practice 24:** Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.

#### **Specifications:**

- Organization should have specific written policies and procedures in place that address exceptions to standard medical care for religious and spiritual reasons (e.g., legal cases involving services such as blood transfusions).

- Policies should be accepting of the benefits of spiritual/religious beliefs.

### **Physical Environment (4.2)**

**Preferred Practice 25:** Adapt the physical environment where the healthcare is being delivered to represent the culture of the populations who access their healthcare in that environment.

#### **Specifications:**

- Prominently display images, artwork, and other decor that reflects, and does not offend, the cultures and ethnic backgrounds of the clients served.
- Provide magazines, brochures, and other printed materials in reception areas that are of interest to and reflect the different cultures of the individuals and families served.
- When using videos, films, or other media resources for health education, treatment, or other interventions, ensure that they reflect the cultures and ethnic background of the individuals and families served.
- Ensure that printed information disseminated takes into account the average literacy levels of the individuals and families receiving services.

### **Coordination of Care (4.4)**

**Preferred Practice 26:** Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.

#### **Specifications:**

- Identify a staff person to coordinate services that reflects the community being served.
- Put systems in place to track referrals and services.
- Follow up on referrals and services to track their completion.

- Intervene with patients who are not getting the services that were referred.

### **Health Information Technology (4.7)**

**Preferred Practice 27:** Explore, evaluate, and consider the use of multimedia approaches and health information technology to enable the provision of healthcare services that are patient and family centered and culturally tailored to the patient.

#### **Specifications:**

- Electronic health records should be equipped to capture the race, ethnicity, and primary written and spoken languages of patients.
- When an electronic health record is used, appropriate information should be shared with patients, taking into account language, cultural diversity, and values.
- Utilize multimedia or health information technology that incorporates the needs of diverse populations to accommodate language, cultural diversity, and health literacy.
- Technology should be adaptable and available to diverse populations with different primary languages and health literacy levels.

## **Domain 5: Workforce Diversity and Training**

### **The Problem**

There is growing evidence that racial and ethnic concordance between providers and patients improves patients' satisfaction, adherence to treatment, and health outcomes.<sup>195</sup> Other evidence suggests that when providers engage a patient in his or her own language, rapport, quality of communication, and understanding increases.<sup>196</sup> Put simply, it is important to have the appropriate staff and resources available to serve diverse populations. Failure in these areas leads to a lack of quality patient care, poor adherence, poor coordination of treatments, and misunderstandings. For example, research suggests that patients who are racially or ethnically diverse are more likely to perceive a bias on the part of their providers and often do not follow up when seeking treatment.<sup>197</sup> A lack of cultural competency and sensitivity among providers may contribute to this problem.<sup>198</sup>

Having a diverse healthcare workforce is not a panacea, but it clearly can improve access to high-quality care for underserved individuals and increase patient satisfaction with care, expand the pool of medical professionals who may serve as policymakers or managers, strengthen the medical research agenda, and, most importantly, advance culturally competent care. Several studies have pointed to the links between the racial and ethnic diversity of the healthcare workforce and healthcare quality.<sup>199</sup> For example, studies have found that when there is racial concordance between doctor and patient—that is,

when they share the same racial or ethnic background—patient satisfaction and self-rated quality of care are higher than when racial or ethnic concordance is not present.<sup>200</sup> Additionally, patient-centered and effective treatment of people of all backgrounds requires that healthcare providers be knowledgeable about cultural belief systems, ethnic origins, nontraditional treatments, and the influence of family structures.<sup>201</sup> Addressing such constructs of culture does not necessarily come from textbooks; it lends itself more to involvement in the environments of the populations being served.

Developing a diverse workforce that reflects the community and the patient population involves the recruitment and retention of a diverse administrative and clinical staff.<sup>202</sup> With the proper strategies in place to recruit, retain, and train staff for the provision of culturally appropriate care, patient trust will increase and the overall quality of care will improve.

A commitment to provide training to healthcare personnel to address the needs of a culturally diverse population is important to attaining cultural competency, given the current demographics of the healthcare workforce. Difficulties in the healthcare system may range from language barriers around informed consent, to problems accessing services or being denied services, to outright discriminatory or culturally insensitive treatment.<sup>203</sup> Training that includes the skills and knowledge that support culturally competent care should be readily available for staff—and in particular for staff who have both clinical or nonclinical patient contact. This training also should be available

for senior managers and administrators.<sup>204</sup> The training should go beyond addressing issues related to patients having access to providers who can speak with patients in their primary written and spoken languages; it must also include changes to the workplace environment and in the availability of resources.<sup>205</sup>

Ultimately, policies, practices, procedures, and programs addressing workforce diversity and training should be integrated systemwide to provide a more meaningful and effective commitment to the delivery of culturally competent care.

## Preferred Practices

### ***Recruitment and Retention (5.1)***

**Preferred Practice 28:** Recruit and hire ethnically diverse providers and staff at all levels, including management levels.

#### **Specifications:**

- In order to support an organizational culture that can better serve the community, promote a system to recruit and retain qualified staff from diverse backgrounds who understand their patients' cultures and communities.
- Human resource managers should assess and report on employee promotions, terminations, and resignations, and should use exit interviews to evaluate how well the organization is doing in promoting and retaining a diverse workforce.
- Annually assess the organization's progress in recruiting, hiring, and retaining qualified bicultural/multicultural employees.

**Practice Statement 29:** Actively promote the retention of a culturally diverse workforce through organizational policies and programs.

**Specifications:**

- Regarding the recruitment and selection process, focus on meeting the needs of the organization's goals for culturally competent care.
- Adopt a personnel policy that creates a comfortable and welcoming work place for employees.
- Have senior executives mentor culturally diverse employees.
- Subcontract with culturally diverse health-care providers.
- Link executive compensation to the steps that are taken to match hiring to community needs.
- Expand on traditional affirmative action programs aimed at attracting employees who match the race and ethnicity of the patient populations.
- Establish a set of principles for the respectful treatment of all people.
- Review the fairness of human resource practices and the compensation of all staff.
- Track staff satisfaction by racial and ethnic groups.

**Training Commitment and Content (5.2)**

**Preferred Practice 30:** Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies. (See also the Leadership subdomain of Policies.)

**Specifications:**

- Include in training materials information regarding in-depth knowledge about the causes of and research on cultural competency, inequities, and healthcare disparities. Also include material related to healthcare and treatment regarding understanding the different cultural beliefs and attitudes of the predominant populations served by the organization.
- Promote a system to recruit and retain qualified staff from diverse backgrounds who understand their patient cultures and communities, in order to support organizational cultures that can better serve communities.
- Provide training opportunities to increase cultural competency skills to assist staff with their responsibilities for direct patient care.
- Annually assess the organization's progress in recruiting, hiring, and retaining qualified bicultural/multicultural employees.
- Human resource managers should assess and report on employee promotions, terminations, and resignations, and should include the use of exit interviews, to evaluate how well the organization is doing in the promotion and retention of a diverse workforce.

## Domain Six: Community Engagement

### The Problem

An important element in improving the provision of culturally competent care and reducing health disparities is one that centers on community engagement. Integrating an understanding of community needs with community collaborations among health institutions, providers, and outreach workers can improve care quality for diverse populations.<sup>206</sup>



Healthcare professionals and organizations should understand the communities they serve, including the social structures and environmental factors that affect health and the perceptions of healthcare.<sup>207</sup> Such community engagement is multifaceted and involves many components, such as conducting needs assessments and community outreach, involving community leaders in program development and decision-making processes, and engaging in CBPR.

Healthcare organizations need to understand their communities, as well as their patient/consumer populations, to provide quality healthcare services. For example, developers of programs often are not sensitive to the cultural norms and boundaries that support or hinder behaviors related to screening, early detection, and prevention.<sup>208</sup> Without informed knowledge about communities and culture, important health and healthcare programs usually are not successful or sustainable.<sup>209</sup> Of note, data collection about *potential*, as well as current, patient populations is important, as is the utilization of as many data sources as possible, including sources outside of the organization itself. Because the characteristics of a community change over time, it also is critical that healthcare organizations ensure that the data they have about their community are up to date. Demographic, cultural, and epidemiological profiles of the community and needs assessments are tools to help organizations understand their communities, and they can help providers and policymakers develop appropriate services and evaluate access to, and utilization of, those services.

A critical component of community engagement involves forming partnerships with leaders, including but not limited to spiritual and social

leaders, community members, and other community networks. Such partnerships clearly can have a positive impact on the health of minority populations. For example, a community partnership with the Haitian community in the Tampa Bay area resulted in more than 80 Haitian women receiving mammograms and clinical breast examinations and approximately 4,500 people receiving educational messages about breast cancer.<sup>210</sup> Support from community gatekeepers, such as clergy, local Haitian nonprofit organizations, and a Haitian outreach worker, helped broaden community interest and provided legitimacy and sustainability to the program.<sup>211</sup>

CBPR also provides an opportunity to tackle health disparities in communities.<sup>212</sup> An assessment of CBPR in environmental and occupational health in the United States found clear evidence that CBPR results in actions that effect community-level change.<sup>213</sup> In 14 of 20 studies, CBPR led to community-level action to improve the health and well-being of the community members. Observational studies that investigated problems posed by the affected community and that incorporated qualitative methods were more likely to lead to action. The collaboration among government scientists, university researchers, and community partners emerged as a new model of CBPR partnerships that effectively integrate research and action. Community needs assessments, partnerships, and CBPR are all considered to be investments.

Robust community engagement has clear benefits for patients, the healthcare community, and the greater healthcare system. A study conducted by the Trust for America's Health found that investing \$10 per person per year in community disease prevention programs

could save the United States \$2.8 billion in healthcare costs over two years and \$16.5 billion over five years.<sup>214</sup> The study analyzed community-based prevention programs that promote physical activity, good nutrition, and smoking cessation. Among the findings were that community health programs could reduce the rates of diabetes and high blood pressure by 5 percent within 2 years and reduce the incidence of some forms of cancer and arthritis within 10 to 20 years.<sup>215</sup>

Community engagement is a cornerstone of providing culturally competent care. To adequately meet the challenges of health disparities within communities, careful consideration of culture must be incorporated in all aspects of program development, message development, and implementation.<sup>216</sup>

## Preferred Practices

### Community Outreach (6.1)

**Preferred Practice 31:** Engage communities to ensure that healthcare providers (individual and organizational) are aware of current and changing patient populations and cultural and communication needs and provide opportunities to share resources and information.

#### Specifications:

- Use quantitative and qualitative data methodologies.
- Engage with local community-based organizations to access their data.
- Use indirect methods such as public health and census data.
- Identify key informants and engage them in interviews and focus groups to learn about shifting cultural practices of the community.

**Preferred Practice 32:** Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.

#### Specifications:

- Organizations should work closely with a community advisory board.
- Organizations should collaborate with community organizations, in particular for health education programs, where they can help to raise awareness about local healthcare services.
- Organizations should partner with the community on specific programs and draw on the experiences and resources in the community to develop training programs, research projects, and outreach activities.

**Preferred Practice 33:** Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating the effectiveness of cultural competency activities.

#### Specifications:

- Patients and community representatives should be actively consulted and involved in a broad range of service design and delivery activities; the use of interpreters and translated materials may enhance such activities.
- Formal and informal mechanisms should be utilized, including participation in governance boards, community advisory committees, ad hoc advisory groups, and community meetings, as well as informal conversations, interviews, and focus groups.

- Healthcare organizations should collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served.

### **Community Investments (6.3)**

**Preferred Practice 34:** Healthcare professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.

#### **Specifications:**

- Work with the community and organization decisionmakers to assess gaps in services.
- Engage in community asset mapping.<sup>217</sup>
- Establish programs and services to complement existing assets.
- Provide stable funding streams to programs until they are sustainable through internal resources.

### **Community-Based Participatory Research (6.4)**

**Practice Statement 35:** Use the methodology of community-based participatory research when conducting research in the community as a collaborative approach to research that equitably involves all stakeholders in the research process and fosters the unique strengths that the community brings to the process.

#### **Specifications:**

- Identify key opinion leaders in the community to assist with decisionmaking involving research study topics and design.<sup>218</sup>

- Engage local knowledge and local theory based on the experience of the people involved to improve the quality and validity of the research.<sup>219</sup>
- Provide resources to and possible employment opportunities for those in the communities involved.
- Recognize existing community resources, and build community capacity to identify and conduct research.<sup>220</sup>

## **Domain 7: Data Collection, Public Accountability, and Quality Improvement**

### **The Problem**

To reduce disparities, data on race, ethnicity, and primary language are essential. These data document where disparities exist, allow for quality improvement and monitoring progress, and provide the foundation for rewarding good performance. The data currently being captured, however, fall short of being able to meet these ends. Despite the obvious benefits of and need for data collection in these areas, the majority of hospitals, health plans, and physician practices do not routinely capture this information. When they do, the data are often not in a useable form.<sup>221</sup> Even fewer link the data to quality measures or use them for quality improvement.<sup>222</sup> Meaningful progress to achieve equity in healthcare quality cannot occur without better data on race, ethnicity, and primary language.<sup>223</sup>

The collection of race and ethnicity data involves many challenges, such as patient concerns that the data will exacerbate discrimination and disparities and patient suspicions

about confidentiality, a need for standardized race and ethnicity codes and electronic health records, and a need for consistent data feeds from multiple providers. There also is concern that there may be unintended consequences that could worsen disparities. Recently, however, The Joint Commission released its Hospitals, Language, and Culture: A Snapshot of the Nation study, which identified how the challenges associated with culture and language are being addressed at 60 hospitals across the country. The Joint Commission found a no “one-size-fits-all” solution, but based on the data gathered, it states that collecting and using data are essential to developing and improving services in healthcare, including services developed to meet the needs of diverse patient populations. Moreover, The Joint Commission specifically calls attention to this as one of six domains in its framework, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*.<sup>224</sup>

The IOM report *Crossing the Quality Chasm* notes that a system is high quality if it provides care that does not vary because of the personal characteristics of patients, such as gender, ethnicity, geographic location, and SES.<sup>225</sup> Systemic cultural competency, which includes processes to monitor and assess the quality of care and detect disparities by stratifying measures by race/ethnicity, would lay the foundation for targeted quality improvement activities.<sup>226</sup> In 2002, IOM released the report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which found that racial and ethnic minorities receive lower quality of care than their white counterparts, even after controlling for factors such as insurance, SES, comorbidities, and stage of

presentation.<sup>227</sup> One important—although not the sole—contributor to these disparities is a lack of culturally competent care.

A critical component to ensure the linkage between culturally competent care and improved outcomes is the collection of race/ethnicity and primary language data from patients. We know that the quality of patient-provider relationships is important—it affects patients’ adherence to treatment regimens and their satisfaction with care. Despite the knowledge of its importance to improving the delivery of culturally competent care and reducing disparities in the quality of care, the collection of race/ethnicity and language data is not systematic or standardized. Stratifying measures by race/ethnicity and primary language will enable physicians, hospitals, healthcare systems, and others to review their quality information to determine where disparities exist and act on them. Additionally, collecting race/ethnicity and primary language data is an integral step if a healthcare organization wants to create a report to examine inequalities in the care provided to patients from different racial, ethnic, and language backgrounds.<sup>228</sup> Such a report can track both areas that need improvement and those that do not and monitor progress toward eliminating healthcare disparities.

More than basic race, ethnicity, and language data need to be collected and integrated into a healthcare provider’s or professional’s quality improvement efforts. Current research suggests that health status is influenced not only by individual attributes such as genetics and health behaviors, but also by the physical, social, and cultural dimensions of a person’s

environment.<sup>229</sup> Healthcare professionals and organizations need to understand their communities, as well as their patient/consumer populations, to provide quality healthcare services. A demographic, cultural, and epidemiological profile of the community and a needs assessment are tools to help organizations and professionals understand their communities. These tools can help providers and policymakers develop appropriate services and evaluate access to, and utilization of, those services.

Many people in a service area, especially individuals with LEP, may be unaware of an organization's services and thus never enroll in its programs. Consequently, it is important to collect data about *potential*, as well as current, patient populations and to use as many data sources as possible, including sources outside the organization itself. Because many characteristics of a community change over time, it also is critical that healthcare organizations and professionals ensure that data on their community are up to date.

## Preferred Practices

### **Collection of Patient Cultural Competency-Related Information (7.1)**

**Preferred Practice 36:** Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit<sup>230</sup> to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner.

#### **Specifications:**

- Use the HRET toolkit as specified. The toolkit is broken down into sections that outline the following: who should use the toolkit; why collect race, ethnicity, and primary language data; why collect data using a uniform

framework; the nuts and bolts of data collection; how to ask questions about race, ethnicity, and primary language; how to use race, ethnicity, and primary language data to improve quality of care; how to train staff to collect this information; how to inform and engage the community; how to address the communication access needs of deaf and hard of hearing populations; available tools and resources; and answers to frequently asked questions.

- Organizations should ensure through the use of policies and procedures that no data are used for discriminatory purposes.

**Preferred Practice 37:** Ensure that, at a minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget [OMB] categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.

#### **Specifications:**

- Use the OMB categories as modified by HRET<sup>231</sup>:
  - OMB Ethnicity: Hispanic or Latino; Not Hispanic or Latino
  - OMB Race: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White
  - HRET Modifications: Multiracial; Declined; Unavailable
- Update the information annually.
- Organizations should ensure by policies and procedures that no data are used for discriminatory purposes.

### **Collection of Community Cultural Competency-Related Information (7.2)**

**Preferred Practice 38:** Utilize indirect data collection methodologies (e.g., geocoding, surname analysis) to characterize the race, ethnicity, and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.

#### **Specifications:**

- Use data to develop and implement population-level interventions.
- Identify resources for target populations.
- Identify gaps in information and data, and use direct methods to fill gaps.
  - Integrate surname and geocoded address information when imputing race/ethnicity.
  - Use geocoded address information at the Block Group or Block Level.
  - Use the most recent Census Bureau surname list for surname analysis.<sup>232</sup>
  - Consider Bayesian methods for integrating surname and geocoded information.<sup>233</sup>
  - Where possible, use continuous, rather than categorical, indirect estimates of race/ethnicity.<sup>234</sup>

**Preferred Practice 39:** Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.

#### **Specifications:**

- Healthcare organizations should regularly use a variety of methods and information sources such as public health data to maintain data on racial and ethnic groups in the service area.

- Data should extend beyond the organization's own data, such as marketing, enrollment, and termination figures, which may provide an incomplete portrait of the potential patient population.
- Data sources such as census figures and/or adjustments, voter registration data, school enrollment profiles, county and state health status reports, and data from community agencies and organizations should be used.
- Quantitative and qualitative methods should be used to determine cultural factors related to patient needs, attitudes, behaviors, health practices, and concerns about using health-care services as well as the surrounding community's resources, assets, and needs.
- Organizations should ensure through policies and procedures that no data are used for discriminatory purposes.
- Organizations should ensure through educational efforts that all patients and the community are aware of the importance of the data and of the nondiscriminatory policies and procedures that are in place.
- After baseline information is obtained, the data should be updated at least biannually.

### **Quality Improvement (7.3)**

**Practice Statement 40:** Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.

#### **Specifications:**

- Identify NQF-endorsed performance measures to collect and use for quality improvement.
- Based on national benchmarks, set organizational targets and benchmarks for performance measures.

- Utilize performance improvement methodology and science such as rapid cycle change and Plan-Do-Study-Act cycles.

### **Accountability (7.4)**

**Preferred Practice 41:** Publicly report data for the applicable NQF-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care<sup>235</sup> stratified by race/ethnicity and primary written and spoken language.

#### **Specifications:**

- As outlined in the NQF report,<sup>236</sup> identify which quality measures are appropriate (a subset or all) to stratify and report on for the population served.
- Utilize the HRET toolkit to collect the race/ethnicity and primary language data.

**Preferred Practice 42:** Regularly make available to the public information about progress and successful innovations in implementing culturally competent programs (especially the NQF-endorsed preferred practices for cultural competency), and provide public notice in communities about the availability of this information. (See also the Leadership domain.)

#### **Specifications:**

- Prepare an annual progress report documenting the organization's progress in implementing culturally competent practices, including information on programs, staffing, and resources.
- Prepare and proactively distribute an annual progress report documenting the organization's progress implementing culturally competent programs (especially the NQF-endorsed preferred practices on cultural competency).

- Ensure that the information provided is readily accessible and community friendly.

### **Assessment of Patient Experiences with Care (7.5)**

**Preferred Practice 43:** Assess and improve patient- and family-centered communication on an ongoing basis.

#### **Specifications:**

- Use the HRET-specified categories to collect the race, ethnicity, and primary written and spoken language of the respondents.
- The design and implementation of communication initiatives should assess the needs of patients, families, and staff.
- Data should be used to build support for initiatives; champions should build support for new communication initiatives by presenting qualitative and quantitative data on communication needs and performance.
- Information on model programs should be collected; site visits to successful programs should be conducted; and/or published guides should be consulted.
- At a minimum, annually utilize focus groups or patient surveys to assess whether patients and their families find that patient-provider communication is effective.

**Preferred Practice 44:** Any surveys created by or conducted by the organization must collect race, ethnicity, and primary written and spoken language, and analysis and results must be stratified by race, ethnicity, and primary written and spoken language.

#### **Specifications:**

- Survey materials must be translated into and conducted in threshold languages.

**Documentation of Cross-Cultural Complaints and Resolutions (7.9)**

**Preferred Practice 45:** Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.

**Specifications:**

- Policies should be in line with the organizations other grievance processes, such as sexual harassment.
- Complaint/grievance mechanisms should be provided to facilitate communication and problem resolution.
- Oversight and monitoring of the frequency and nature of cross-cultural complaints and grievances and their resolution should occur and be an integral part of the organization’s quality assurance program.
- An annual report of all cultural and language access complaints should be prepared by the champions and provided to the leadership.

- Notices should be provided in threshold languages, at minimum, and potentially in other languages, about the right of each patient to file a complaint or grievance.
- A staff member should acknowledge the receipt of a patient’s grievance orally or in writing within a timely number of working days and shall include the name and contact information of the appropriate official.

**Areas Recommended for Further Research**

A number of practices evaluated in this project met the threshold criterion of specificity but failed to meet one or more of the other criteria. Based on the evaluations, however, a list of research areas was developed (Table 2). This list is not all inclusive, but these areas hold promise and should be given high priority for additional research.

---

**Table 2: Areas Recommended for Further Research**

---

Cultural competency research should include the following:

- methods to ascertain the successful implementation of the practices;
  - research studies to link the implementation of the practices to improved health outcomes;
  - identification of any possible unintended consequences that may arise from the use of the practices;
  - use of oral translation and when its use is appropriate;
  - unintended consequences around distributing the race/ethnicity of healthcare providers; and
  - pharmacogenetics.
-



## Relationship to Other NQF-Endorsed Consensus Standards

This report does not represent the entire scope of NQF work relevant to cultural competency. In 2008, NQF identified addressing health-care disparities as a national imperative and developed a set of disparities-sensitive measures that could be used for public reporting, quality, and disparities improvement at the practice level.<sup>237</sup> Specifically, NQF endorsed a set of 35 performance measures in 8 areas. In addition, NQF identified a measure of experience of care that is “disparities sensitive,” comprehensive, and broadly applicable in ambulatory settings. NQF also endorsed a set of disparities-sensitive measures that addresses community-level performance. The set includes 14 Agency for Healthcare Research and Quality Prevention Quality Indicators collected from hospital discharge data that cover hospitalizations that might have been avoidable if appropriate ambulatory care had been provided.<sup>238</sup>

NQF’s *Improving Healthcare Quality for Minority Patients: Workshop Summary* explored how measurement and reporting strategies can be used to improve healthcare quality for minority patients.<sup>239</sup> Additionally, in May 2003, NQF published *Safe Practices for Better Healthcare*, a report (updated in 2006 and 2009)<sup>240</sup> documenting 30 NQF-endorsed practices that should be used universally to reduce the risk of harm resulting from processes,

systems, or environments of care (with the 2009 update, the practices now number 34). In December 2003, NQF initiated a project as a follow-up to this report to identify strategies for accelerating widespread adoption of the NQF-endorsed voluntary consensus standard for informed consent, or Safe Practice 10 (known as Safe Practice 2 in the Safe Practice 2006 update and as Safe Practice 5 in the 2009 update). Safe Practice 10 stood out among the 30 safe practices because of its relevance across clinical areas, its focus on patient-centered care, and its importance to patients who are particularly vulnerable to receiving poor-quality care and to being exposed to medical errors because of communication barriers. This report on culturally competent care includes that practice (Practice 19). A separate NQF publication, *Implementing a National Voluntary Consensus Standard for Informed Consent: A User’s Guide for Healthcare Professionals*, provides a concrete tool for assisting healthcare administrators, providers, interpreters, and others in implementing and using Safe Practice 10.<sup>241</sup> Most recently, NQF released *National Framework and Preferred Practices for Palliative and Hospice Care*, a report that endorsed two practices about culturally appropriate end-of-life care.<sup>242</sup>

## References

- 1 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(Suppl 3):68-79.
- 2 Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academies Press; 2002.
- 3 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(Suppl 3):68-79.
- 4 Department of Health and Human Services (DHHS), Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 5 Ibid.
- 6 IOM, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press; 2001.
- 7 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(Suppl 3):68-79.
- 8 Cox T, *Cultural Diversity in Organizations: Theory, Research & Practice*, San Francisco: Berrett-Koehler; 1994.
- 9 Georgetown University Center for Child and Human Development, *Rationale for Cultural Competency in Primary Care*, Washington, DC: National Center for Cultural Competence; 2003. Available at [www11.georgetown.edu/research/guchd/nccc/documents/Policy\\_Brief\\_1\\_2003.pdf](http://www11.georgetown.edu/research/guchd/nccc/documents/Policy_Brief_1_2003.pdf). Last accessed July 2008.
- 10 Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model, *Med Care Res Rev*, 2000;57(Suppl 1):181-217.
- 11 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 12 National Initiative for Children's Healthcare Quality (NICHQ), *Improving Cultural Competency in Children's Health Care*, Cambridge, MA: NICHQ; 2005. Available at [www.nichq.org/childhood\\_obesity/tools/NICHQ\\_CulturalCompetencyFINAL.pdf](http://www.nichq.org/childhood_obesity/tools/NICHQ_CulturalCompetencyFINAL.pdf). Last accessed February 2009.
- 13 Goode TD, Dunne MC, Bronheim SM, *The Evidence Base for Cultural and Linguistic Competency in Health Care*, New York: The Commonwealth Fund; October 2006. Available at [www.commonwealthfund.org/usr\\_doc/Goode\\_evidencebaseculinguisticcomp\\_962.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Goode_evidencebaseculinguisticcomp_962.pdf?section=4039). Last accessed February 2009.
- 14 Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model, *Med Care Res Rev*, 2000;57(Suppl 1):181-217.
- 15 California Pan-Ethnic Health Network (CPEHN), *Diverse Patients, Disparate Experience: The Use of Standardized Patient Satisfaction Surveys in Assessing the Cultural Competence of Health Care Organizations*, Oakland, CA: CPEHN; 2001. Available at [www.cpehn.org/pdfs/CPEHN%20Final%2001.pdf](http://www.cpehn.org/pdfs/CPEHN%20Final%2001.pdf). Last accessed February 2009.
- 16 Campinha-Bacote J, Yahle T, Langenkamp M, The challenge of cultural diversity for nurse educators, *J Contin Educ Nurs*, 1996;27(2):59-64.
- 17 Curtis EF, Dreachslin JL, Sinioris M, Diversity and cultural competence training in health care organizations: hallmarks of success, *Health Care Manag*, 2007;26(3):255-262.
- 18 Dreachslin JL, Myers VL, A systems approach to culturally and linguistically competent care, *J Healthc Manag*, 2007;2(4):220-226.
- 19 Scott WR, Davis GF, *Organizations and Organizing: Rational, Natural and Open System Perspective*, Upper Saddle River, NJ: Pearson/Prentice Hall; 2007.
- 20 Weech-Maldonado R, Dreachslin JL, Dansky KH, et al., Racial/ethnic diversity management and cultural competency: the case of Pennsylvania hospitals, *J Healthcare Manag*, 2002;47(2):111-124.
- 21 Muller HJ, Haase BE, Managing diversity in health services organizations, *Hosp Health Serv Adm*, 1994;39(4):415-434.
- 22 Brach C, Paez K, Fraser I, *Cultural Competence California Style*, Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2006. Available at [www.gold.ahrq.gov/pdf/70.pdf](http://www.gold.ahrq.gov/pdf/70.pdf). Last accessed February 2009.

- 23 Dansky KH, Weech-Maldonado R, De Souza G, et al., Organizational strategy and diversity management: diversity sensitive orientation as a moderating influence, *Health Care Manag Rev*, 2003;28(3):243-253.
- 24 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 25 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(Suppl 3):68-79.
- 26 Cox T, *Cultural Diversity in Organizations: Theory, Research & Practice*, San Francisco: Berrett-Koehler; 1994.
- 27 Georgetown University Center for Child and Human Development, *Rationale for Cultural Competency in Primary Care*, Washington, DC; National Center for Cultural Competence; 2003. Available at [www11.georgetown.edu/research/gucchd/nccc/documents/Policy\\_Brief\\_1\\_2003.pdf](http://www11.georgetown.edu/research/gucchd/nccc/documents/Policy_Brief_1_2003.pdf). Last accessed July 2008.
- 28 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 29 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 30 Brach C, Paez K, Fraser I, *Cultural Competence California Style*, Rockville, MD: AHRQ; 2006.
- 31 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 32 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 33 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 34 Dreachslin J, Hobby F, Racial and ethnic disparities: why diversity leadership matters, *J Healthc Manag*, 2008;53(1): 8-13, p. 9.
- 35 Georgetown University Center for Child and Human Development, *Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers*, Washington, DC; National Center for Cultural Competence; 2003. Available at [www11.georgetown.edu/research/gucchd/nccc/documents/Policy\\_Brief\\_2\\_2003.pdf](http://www11.georgetown.edu/research/gucchd/nccc/documents/Policy_Brief_2_2003.pdf). Last accessed July 2008.
- 36 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 37 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 38 Betancourt JR, Green AR, Carrillo JE, et al., Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care, *Public Health Rep*, 2003;118(4):293-302.
- 39 Ibid.

- 40 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 41 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 42 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 43 Ibid.
- 44 Hrebiniak LG, Joyce W, *Implementing Strategy*, New York: Macmillan; 1984.
- 45 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 46 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 47 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 48 DHHS, Office of Minority Health, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*, Washington, DC: DHHS, Office of Minority Health; 2005. Available at [www.omhrc.gov/templates/content.aspx?ID=4375](http://www.omhrc.gov/templates/content.aspx?ID=4375). Last accessed February 2009.
- 49 Ibid.
- 50 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(Suppl 3):68-79.
- 51 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 52 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 53 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(Suppl 3):68-79.
- 54 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 55 Karliner LS, Jacobs EA, Chen AH, et al., Do professional interpreters improve clinical care for patients with limited English proficiency? a systematic review of the literature. *Health Serv Res*, 2007;42(2):727-754.
- 56 Interagency Language Roundtable, *Self-Appraisal of Speaking Proficiency*. Available at [www.govtllr.org/Publications/Speaking%20Self-Assessment-1.html](http://www.govtllr.org/Publications/Speaking%20Self-Assessment-1.html). Last accessed July 2008.

- 57 National Coalition on Healthcare Interpretation, Report, Inaugural Meeting, May 29-30, 2008. Available at [http://data.memberclicks.com/site/ncihc/National\\_Coalition\\_on\\_HC\\_Interpreter\\_Certification\\_May\\_20\\_.pdf](http://data.memberclicks.com/site/ncihc/National_Coalition_on_HC_Interpreter_Certification_May_20_.pdf). Last accessed February 2009; Certification of Health Care Interpreters in the United States, Los Angeles, CA: The California Endowment; 2006. Available at [www.mmia.org/uploads/pages/195.pdf](http://www.mmia.org/uploads/pages/195.pdf). Last accessed February 2009.
- 58 Grantmakers In Health, *In the Right Words: Addressing Language and Culture in Providing Health Care*, San Francisco, CA: Grantmakers In Health; 2003. Available at [www.gih.org/usr\\_doc/In\\_the\\_Right\\_Words\\_Issue\\_Brief.pdf](http://www.gih.org/usr_doc/In_the_Right_Words_Issue_Brief.pdf). Last accessed February 2009.
- 59 Jacobs EA, Lauderdale DS, Meltzer D, et al., Impact of interpreter services on delivery of health care to limited English-proficient patients, *J Gen Intern Med*, 2001;16(7):468-474.
- 60 Tocher TM, Larson EB, Do physicians spend more time with non-English-speaking patients? *J Gen Intern Med*, 1999;14(5):303-309.
- 61 Enguidanos ER, Rosen P, Language as a factor affecting follow-up compliance from the emergency department, *J Emerg Med*, 1997;15(1):9-12.
- 62 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 63 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence: Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 64 Weech-Maldonado R, Weidmer BO, Morales LS, et al., Cross-cultural adaptation of survey instruments: the CAHPS experience. In: Cynamon M, Kulka R (eds.), *Seventh Conference on Health Survey Research Methods*, pp. 75-82, Hyattsville, MD: DHHS; 2001. Available at [www.cdc.gov/nchs/data/conf/conf07.pdf](http://www.cdc.gov/nchs/data/conf/conf07.pdf). Last accessed January 2009.
- 65 DHHS, *Healthy People 2010*. Available at [www.healthypeople.gov/lhi](http://www.healthypeople.gov/lhi). Last accessed December 2005.
- 66 Center for Health Care Strategies, Inc., *What Is Health Literacy? Fact Sheet 1 to 9*, Hamilton, NJ: Center for Health Care Strategies, Inc. Available at [www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=291711](http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711). Last accessed April 2008.
- 67 Ad Hoc Committee on Health Literacy for the Council of Scientific Affairs, Health literacy: report of the Council on Scientific Affairs, *JAMA*, 1999;281(6):552-557.
- 68 Williams MV, Davis T, Parker, et al., The role of health literacy in patient-physician communication, *Fam Med*, 2002;34(5):383-389.
- 69 Center for Healthcare Strategies, *Strategies to Assist Low-literate Health Care Consumers*, Hamilton, NJ: Center for Health Care Strategies, Inc. Available at [www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=291711](http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711). Last accessed April 2008.
- 70 Campinha-Bacote J, The process of cultural competence in the delivery of healthcare services: a model of care, *J Transcult Nurs*, 2002;13(3):181-184.
- 71 Kim-Godwin YS, Clarke PN, Barton L, A model for the delivery of culturally competent community care, *J Adv Nurs*, 2001;35(6):918-925.
- 72 DeRosa N, Kochurka K, Implement culturally competent care in your workplace, *Nurs Manage*, 2006;37(10):18-26.
- 73 Lavizzo-Mourey R, McKenzie ER, Cultural competence: essential measurements of quality for managed care organizations, *Ann Int Med*, 1996;124(10):919-921.
- 74 Winkelman M, *Cultural Awareness, Sensitivity & Competence*, Peosta, IA: Eddie Bowers Publishing; 2005.
- 75 Campinha-Bacote J, The process of cultural competence in the delivery of healthcare services: a model of care, *J Transcult Nurs*, 2002;13(3):181-184.
- 76 Kim-Godwin YS, Clarke PN, Barton L, A model for the delivery of culturally competent community care, *J Adv Nurs*, 2001;35(6):918-925.
- 77 DeRosa N, Kochurka K, Implement culturally competent care in your workplace, *Nurs Manage*, 2006;37(10):18-26.

- 78 Campinha-Bacote J, The process of cultural competence in the delivery of healthcare services: a model of care, *J Transcult Nurs*, 2002;13(3):181-184.
- 79 Kim-Godwin YS, Clarke PN, Barton L, A model for the delivery of culturally competent community care, *J Adv Nurs*, 2001;35(6):918-925.
- 80 DeRosa N, Kochurka K, Implement culturally competent care in your workplace, *Nurs Manage*, 2006;37(10):18-26.
- 81 Hobgood C, Sawning S, Bowen J, et al., Teaching culturally appropriate care: a review of educational models and methods, *Acad Emerg Med*, 2006;13(12):1288-1295.
- 82 Carrillo JE, Green AR, Betancourt JR, Cross-cultural primary care: a patient-based approach, *Ann Intern Med*, 1999;130(10):829-834.
- 83 Betancourt JR, Green AR, Carrillo JE, et al., Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care, *Public Health Rep*, 2003;118(4):293-302.
- 84 Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model, *Med Care Res Rev*, 2000;57(Suppl 1):187-217.
- 85 Taylor SL, Lurie N, The role of culturally competent communication in reducing ethnic and racial healthcare disparities, *Am J Manag Care*, 2004;Spec No:SP1-4.
- 86 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 87 Ibid.
- 88 Ibid.
- 89 Ibid.
- 90 Betancourt JR, Green AR, Carrillo JE, et al., Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care, *Public Health Rep*, 2003;118(4):293-302.
- 91 Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model, *Med Care Res Rev*, 2000;57(Suppl 1):187-217.
- 92 Cooper LA, Roter DL, Johnson RL, et al., Patient-centered communication, ratings of care, and concordance of patient and physician race, *Ann Intern Med*, 2003;139(11):907-915.
- 93 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 94 Ngo-Metzger Q, Telfair J, Sorkin DL, et al., *Cultural Competency and Quality of Care: Obtaining the Patient's Perspective*, New York: The Commonwealth Fund; 2006. Available at [www.commonwealthfund.org/usr\\_doc/Ngo-Metzger\\_cultcompqualitycareobtainpatientperspect\\_963.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Ngo-Metzger_cultcompqualitycareobtainpatientperspect_963.pdf?section=4039). Last accessed February 2009.
- 95 Betancourt JR, Green AR, Carrillo JE, et al., Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care, *Public Health Rep*, 2003;118(4):293-302.
- 96 Dreachslin JL, Hobby F, Racial and ethnic disparities: why diversity leadership matters, *J Healthc Manag*, 2008;53(1):8-13.
- 97 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamod.org/pdf/CLASfinalreport.pdf](http://www.nhmamod.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 98 Ibid.
- 99 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(Suppl 3):68-79.
- 100 Dreachslin JL, Hobby F, Racial and ethnic disparities: why diversity leadership matters, *J Healthc Manag*, 2008;53(1):8-13.
- 101 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamod.org/pdf/CLASfinalreport.pdf](http://www.nhmamod.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.

- 102 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 103 Ibid.
- 104 Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: a systematic review, *Am J Prev Med*, 2003;24(3):68-79.
- 105 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 106 Ibid.
- 107 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 108 Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model, *Med Care Res Rev*, 2000;57(Suppl 1):187-217.
- 109 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 110 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 111 Kairys JA, Stroebel CK, Using the Participatory Quality Improvement (PQI) model to improve the health of diverse communities, *JCAHO Benchmark*, 2001;3(5):6-7.
- 112 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 113 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002. Available at [www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf](http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf). Last accessed February 2009.
- 114 Betancourt JR, Green AR, Carrillo JE, et al., *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, New York: The Commonwealth Fund; 2002. Available at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=274805](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=274805). Last accessed February 2009.
- 115 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007.
- 116 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 117 The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, Falls Church, VA: The Lewin Group; 2002.
- 118 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 119 Weiner BJ, Alexander JA, Shortell SM, et al., Quality improvement implementation and hospital performance on quality indicators, *Health Serv Res*, 2006;42(2):307-334.
- 120 Hospital Compare. Available at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov). Last accessed January 2009.

- 121 Geisinger. Available at [www.geisinger.org/quality/](http://www.geisinger.org/quality/). Last accessed January 2009.
- 122 Colmers JM, *Public Reporting and Transparency*, New York: The Commonwealth Fund; 2007. Available at [www.commonwealthfund.org/usr\\_doc/Colmers\\_pubreportingtransparency\\_988.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Colmers_pubreportingtransparency_988.pdf?section=4039). Last accessed February 2009.
- 123 Schneider EC, Lieberman T, Publicly disclosed information about the quality of health care: response of the U.S. public, *Qual Health Care*, 2001;10(2):96-103.
- 124 Marshall MN, Shekelle PG, Leatherman S, et al., The public release of performance data: what do we expect to gain? a review of the evidence, *JAMA*, 2000;283(14):1866-1874.
- 125 Weech-Maldonado R, Weidmer BO, Morales LS, et al., Cross-cultural adaptation of survey instruments: the CAHPS experience. In: M Cynamon, R Kulka (eds.), *Seventh Conference on Health Survey Research Methods*, pp. 75-82, Hyattsville, MD: DHHS; 2001 (February). Available at [www.cdc.gov/nchs/data/conf/conf07.pdf](http://www.cdc.gov/nchs/data/conf/conf07.pdf). Last accessed January 2009.
- 126 Weech-Maldonado R, Morales LS, Elliot M, et al., Race/ethnicity, language and patient's assessments of care in Medicaid managed care, *Health Serv Res*, 2003;38(3): 789-808.
- 127 Ibid.
- 128 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 129 Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 130 Dreachslin JL, Myers VL, A systems approach to culturally and linguistically competent care, *J Healthc Manag*, 2007;52(4):220-226.
- 131 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 132 Betancourt JR, Green AR, Carrillo JE, et al., Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care, *Public Health Rep*, 2003;118(4):293-302.
- 133 National Center for Cultural Competence, *Cultural and Linguistic Competence Policy Assessment and Guide Cultural Competence Health Practitioner Assessment*, Washington, DC: Georgetown University. Available at [www11.georgetown.edu/research/guchd/nccc/features/CCHPA.html](http://www11.georgetown.edu/research/guchd/nccc/features/CCHPA.html). Last accessed July 2009.
- 134 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 135 Ibid.
- 136 Chin JL, Culturally competent health care, *Public Health Rep*, 2000;115(1):25-33.
- 137 Passel JS, Cohn D, *U.S. Population Projections: 2005–2050*, Washington, DC: Pew Research Center; 2008. Available at <http://pewhispanic.org/files/reports/85.pdf>. Last accessed February 2009.
- 138 Betancourt JR, Green AR, Carrillo JE, et al., Cultural competence and health care disparities: key perspectives and trends. *Health Aff*, 2005;24(4):499-505.
- 139 The California Endowment, *A Manager's Guide to Cultural Competence Education for Healthcare Professionals*, Woodland Hills, CA: The California Endowment; 2003. Available at [www.calendow.org/uploadedfiles/managers\\_guide\\_cultural\\_competence\(1\).pdf](http://www.calendow.org/uploadedfiles/managers_guide_cultural_competence(1).pdf). Last accessed February 2009.
- 140 Campinha-Bacote J, Yahle T, Langenkamp M, The challenge of cultural diversity for nurse educators, *J Contin Educ Nurs*, 1996;27(2):59-64.



- 141 Betancourt JR, Green AR, Carrillo JE, *Cultural Competence in Healthcare: Emerging Frameworks and Practical Approaches*, New York: The Commonwealth Fund; 2002. Available at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=274805](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=274805). Last accessed February 2009.
- 142 Flores G, Culture and the patient-physician relationship: achieving cultural competency in healthcare, *J Pediatr*, 2000;136(1):14-23.
- 143 Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 144 Betancourt JR, Green AR, Carrillo JE, *Cultural Competence in Healthcare: Emerging Frameworks and Practical Approaches*, New York: The Commonwealth Fund; 2002. Available at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=274805](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=274805). Last accessed February 2009.
- 145 Ibid.
- 146 Betancourt JR, Green AR, Carrillo JE, et al., Cultural competence and health care disparities: key perspectives and trends, *Health Aff*, 2005;24(2):499-505.
- 147 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001, pp. 83-87. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 148 Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 149 Johnson RL, Saha S, Arbelaez J, et al., Racial and ethnic differences in patient perceptions of bias and cultural competence in health care, *J Gen Intern Med*, 2004;19(2):101-110.
- 150 Ibid.
- 151 Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 152 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001, pp. 83-87. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 153 Wilson-Stronks A, Lee KK, Cordero CL, et al., *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf](http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf). Last accessed February 2009.
- 154 Ibid.
- 155 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001, pp. 83-87.
- 156 Wilson-Stronks A, Lee KK, Cordero C, et al., *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf](http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf). Last accessed February 2009.
- 157 Betancourt JR, Green AR, Carrillo JE, et al., Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care, *Public Health Rep*, 2003;118(4):293-302.
- 158 DHHS, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: DHHS, Office of Minority Health; 2001, pp. 83-87. Available at [www.nhmamd.org/pdf/CLASfinalreport.pdf](http://www.nhmamd.org/pdf/CLASfinalreport.pdf). Last accessed January 2009.
- 159 Weech-Maldonado R, *A Cultural Competency Framework for Quality Measurement and Reporting*, Washington, DC: National Quality Forum (NQF); 2008.

- 160 National Center for Healthcare Leadership, "Strategies for Leadership. Does your hospital reflect the community it serves?" *A Diversity and Cultural Assessment Tool for Leaders*, Chicago, IL: National Center for Healthcare Leadership; 2004.
- 161 Wilson-Stronks A, Lee KK, Cordero C, et al., *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdoonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf](http://www.jointcommission.org/NR/rdoonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf). Last accessed February 2009.
- 162 DHHS, *Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (OCR LEP Guidance), 68 Fed Reg. 47311, August 8, 2003. Available at [www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf](http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf). Last accessed February 2009.
- 163 IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academies Press; 2002. Available at [http://books.nap.edu/html/unequal\\_treatment/reportbrief.pdf](http://books.nap.edu/html/unequal_treatment/reportbrief.pdf). Last accessed February 2009.
- 164 Flores G, Language barriers to health care in the United States: perspective, *N Engl J Med*, 2006;355(3):229-231.
- 165 Piette JD, Schillinger D, Potter MB, et al., Dimensions of patient-provider communication and diabetes self-care in an ethnically diverse population, *J Gen Intern Med*, 2003;18(8):624-633.
- 166 Cooper LA, Roter AL, Patient-provider communication: the effect of race and ethnicity on process and outcomes of healthcare, In: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, pp. 552-780, Washington, DC: National Academies Press; 2003.
- 167 Piette JD, Schillinger D, Potter MB, et al., Dimensions of patient-provider communication and diabetes self-care in an ethnically diverse population, *J Gen Intern Med*, 2003;18(8):624-633.
- 168 The Commonwealth Fund, *Providing Language Services in Small Healthcare Provider Settings: Examples from the Field*, New York: The Commonwealth Fund; 2005. Available at [www.commonwealthfund.org/usr\\_doc/810\\_Youdelman\\_providing\\_language\\_services.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf?section=4039). Last accessed February 2009.
- 169 Stokols D, Translating social ecological theory into guidelines for community health promotion, *Am J Health Promot*, 1996;10(4):282-298.
- 170 IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academies Press; 2002. Available at [http://books.nap.edu/html/unequal\\_treatment/reportbrief.pdf](http://books.nap.edu/html/unequal_treatment/reportbrief.pdf). Last accessed February 2009.
- 171 The Commonwealth Fund, *Providing Language Services in Small Healthcare Provider Settings: Examples from the Field*, New York: The Commonwealth Fund; 2005. Available at [www.commonwealthfund.org/usr\\_doc/810\\_Youdelman\\_providing\\_language\\_services.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf?section=4039). Last accessed February 2009.
- 172 Flores G, Language barriers to health care in the United States: perspective, *N Engl J Med*, 2006;355(3):229-231.
- 173 Jacobs EA, Lauderdale DS, Meltzer D, et al., Impact of interpreter services on delivery of healthcare to limited-English-proficient patients, *J Gen Intern Med*, 2001;16(7):468-474.
- 174 Flores G, Language barriers to health care in the United States: perspective, *N Engl J Med*, 2006;355(3):229-231.
- 175 Weech-Maldonado R, *A Cultural Competency Framework for Quality Measurement and Reporting*, Washington, DC: NQF; 2008.
- 176 Hopper KD, TenHave TR, Tully DA, et al., The readability of currently used surgical/procedure consent forms in the United States, *Surgery*, 1998;123(5):496-503.
- 177 American Medical Association (AMA), Ad Hoc Committee on Health Literacy for the Council of Scientific Affairs, Health literacy: report of the Council on Scientific Affairs, *JAMA*, 1999;281(6):552-557.
- 178 IOM, *Health Literacy: A Prescription to End Confusion*, Washington, DC: National Academies Press; 2004. Available at [http://books.nap.edu/html/health\\_literacy/reportbrief.pdf](http://books.nap.edu/html/health_literacy/reportbrief.pdf). Last accessed February 2009.

- 179 Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model, *Med Care Res Rev*, 2000;57(Suppl 1):187-217.
- 180 Blackhall LJ, Murphy ST, Frank G, et al., Ethnicity and attitudes toward patient autonomy, *JAMA*, 1995;274(10):820-825.
- 181 Armstrong K, Hughes-Halbert C, Asch DA, Patient preferences can be misleading as explanations for racial disparities in health care, *Arch Intern Med*, 2006;166(9):950-954.
- 182 Crandall SJ, George G, Marion GS, et al., Applying theory to the design of cultural competency training for medical students: a case study, *Acad Med*, 2003;78(6):588-594.
- 183 Weech-Maldonado R, *A Cultural Competency Framework for Quality Measurement and Reporting*, Washington, DC: NQF; 2008.
- 184 Youdelman M, Perkins J, *Providing Language Services in Small Healthcare Provider Settings: Examples from the Field*, New York: The Commonwealth Fund; 2005, pp. 3-14. Available at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=270667](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=270667). Last accessed February 2009.
- 185 NQF, *Implementing a National Voluntary Consensus Standard for Informed Consent: A User's Guide for Healthcare Professionals*, Washington, DC: NQF; 2005.
- 186 National Center for Cultural Competence, Georgetown University, *A Guide to Planning and Implementing Cultural Competence*, Washington, DC: National Center for Cultural Competence; 2002. Available at [www11.georgetown.edu/research/gucchd/NCCC/documents/ncccorgselfassess.pdf](http://www11.georgetown.edu/research/gucchd/NCCC/documents/ncccorgselfassess.pdf). Last accessed February 2009.
- 187 Gornick ME, Disparities in Medicare services: potential causes, plausible explanations and recommendations, *Health Care Financ Rev*, 2000;21(4):23-43.
- 188 Coleman-Miller B, A physician's perspective on minority health, *Health Care Financ Rev*, 2000;21(4):45-56.
- 189 Williams DR, Rucker TD, Understanding and addressing racial disparities in health care, *Health Care Financ Rev*, 2000;21(4):75-90.
- 190 Paasche-Orlow M, The ethics of cultural competency, *Acad Med*, 2004;79(4):347-350.
- 191 Mead H, Regenstein M, Lara A, The heart of the matter: the relationship between communities, cardiovascular services and racial and ethnic gaps in care, *Manage Care Interface*, 2007;20(8):22-28.
- 192 Einbinder LC, Schulman KA, The effect of race on the referral process for invasive cardiac procedures, *Med Care Res Rev*, 2000;57(Suppl 1):162-180.
- 193 NQF, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*, Washington, DC: NQF; 2006, pp. 36-38.
- 194 Ibid.
- 195 Cohen JJ, Gabriel BA, Terrell C, The case for diversity in the health care workforce, *Health Aff*, 2002;21(5):90-102.
- 196 Ibid.
- 197 Johnson RL, Saha S, Arbelaez J, et al., Racial and ethnic differences in patient perceptions of bias and cultural competence in health care, *J Gen Intern Med*, 2004;19(2):101-110.
- 198 Weech-Maldonado R, *A Cultural Competency Framework for Quality Measurement and Reporting*, Washington, DC: NQF; 2008, pp. 5-10.
- 199 Betancourt JR, Green AR, Carrillo JE, *Cultural Competence in Healthcare: Emerging Frameworks and Practical Approaches*, New York: The Commonwealth Fund; 2002. Available at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=274805](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=274805). Last accessed February 2009.
- 200 Ibid.
- 201 Cohen JJ, Gabriel BA, Terrell C, The case for diversity in the health care workforce, *Health Aff*, 2002;21(5):90-102.
- 202 Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 203 Los Angeles County Department of Health Services, *Cultural and Linguistic Competency Standards*, Los Angeles: Los Angeles County Department of Health Services; 2003, pp. 15-22.
- 204 Ibid.

- 205 Ibid.
- 206 Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008, pp. 60-64. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 207 Ibid.
- 208 Meade CD, Menard J, Martinez D, et al., Impacting health disparities through community outreach: utilizing the CLEAN look (Culture, Literacy, Education, Assessment, and Networking), *Cancer Control*, 2007;14(1):70-77.
- 209 Ibid.
- 210 Ibid.
- 211 Ibid.
- 212 Horowitz CR, Arniella A, James S, et al., Community-based participatory research to reduce health disparities in East and Central Harlem, *Mt Sinai J Med*, 2004;71:368-374.
- 213 Cook WK, Integrating research and action: a systematic review of community-based participatory research to address health disparities in environmental and occupational health in the USA, *J Epidemiol Community Health*, 2008;62(8): 668-676.
- 214 Trust for America's Health, *Investments in Disease Prevention Yield Significant Savings, Stronger Communities*. Available at <http://healthyamericans.org/reports/prevention08/>. Last accessed August 2008.
- 215 Ibid.
- 216 Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008, pp. 60-64. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009.
- 217 Asset Based Community Development Institute, Evanston, IL: Northwestern University Institute for Policy Research. Available at [www.sesp.northwestern.edu/abcd/](http://www.sesp.northwestern.edu/abcd/). Last accessed January 2009.
- 218 Seifer SD, Shore N, Holmes SL, *Developing and Sustaining Community-University Partnerships for Health Research: Infrastructure Requirements*, Seattle, WA: Community-Campus Partnerships for Health; 2003. Available at [http://depts.washington.edu/ccph/pdf\\_files/p-nih012903.pdf](http://depts.washington.edu/ccph/pdf_files/p-nih012903.pdf). Last accessed February 2009.
- 219 Ibid.
- 220 Ibid.
- 221 National Health Law Program, *51-State Survey of Assessment of State Laws, Regulations and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans*, Los Angeles, CA: National Health Law Program. Available at [www.healthlaw.org/library/item.157293-51State\\_Survey\\_of\\_Assessment\\_of\\_State\\_Laws\\_Regulations\\_and\\_Practices\\_Affect](http://www.healthlaw.org/library/item.157293-51State_Survey_of_Assessment_of_State_Laws_Regulations_and_Practices_Affect). Last accessed January 2009.
- 222 Speaking Together: National Language Services Network, *Performance Measures*, Washington, DC: George Washington University Medical Center, School of Public Health and Health Services. Available at [www.speakingtogether.org/measures](http://www.speakingtogether.org/measures). Last accessed October 2008.
- 223 Expecting Success, *Collecting Data on Patient Race, Ethnicity and Primary Language Is Helping Hospitals Improve the Quality of Care*. Available at [www.expectingsuccess.org/uploads/ESdatacollectionissuebriefFINAL.pdf](http://www.expectingsuccess.org/uploads/ESdatacollectionissuebriefFINAL.pdf). Last accessed October 2008.
- 224 Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). Last accessed February 2009; Wilson-Stronks A, Lee KK, Cordero CL, et al., *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*, Oakbrook Terrace, IL: The Joint Commission; 2008. Available at [www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf](http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf). Last accessed February 2009.
- 225 IOM, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press; 2001.

- 226 Betancourt JR, *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*, New York: The Commonwealth Fund; 2006. Available at [www.commonwealthfund.org/user\\_doc/Betancourt\\_improvingqualityachievingequity\\_961.pdf?section=4039](http://www.commonwealthfund.org/user_doc/Betancourt_improvingqualityachievingequity_961.pdf?section=4039). Last accessed February 2009.
- 227 IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academies Press; 2002.
- 228 Weinick RM, Flaherty K, Bristol SJ, *Creating Equity Reports: A Guide for Hospitals*, Princeton, NJ: Robert Wood Johnson Foundation; 2008. Available at [www.rwjf.org/files/research/050608hospitalaequityreport.pdf](http://www.rwjf.org/files/research/050608hospitalaequityreport.pdf). Last accessed February 2009.
- 229 Stokols D, Translating social ecological theory into guidelines for community health promotion, *Am J Health Promot*, 1996;10(4):282-298.
- 230 Hasnain-Wynia R, Pierce D, Haque A, et al., *Health Research and Educational Trust Disparities Toolkit*, Chicago, IL: Health Research & Educational Trust. Available at <http://hreditdisparities.org>. Last accessed September 2008.
- 231 Office of Management and Budget (OMB), *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, Washington, DC: OMB. Available at [www.whitehouse.gov/omb/fedreg/ombdir15.html](http://www.whitehouse.gov/omb/fedreg/ombdir15.html). Last accessed January 2009.
- 232 Word DL, Coleman CD, Nunziata R, et al., *Demographic Aspects of Surnames from Census 2000*. Available at [www.census.gov/genealogy/www/surnames.pdf](http://www.census.gov/genealogy/www/surnames.pdf). Last accessed April 2009.
- 233 Elliott MN, Fremont A, Morrison PA, et al., A new method for estimating race/ethnicity and associated disparities where administrative records lack self-reported race/ethnicity, *Health Serv Res*, 2008;(43):1722-1736.
- 234 Ibid.
- 235 NQF, *National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities*, Washington, DC: NQF; 2008.
- 236 Ibid.
- 237 Ibid.
- 238 Ibid.
- 239 NQF, *Improving Healthcare Quality for Minority Patients: Workshop Summary*, Washington, DC: NQF; 2002.
- 240 NQF, *Safe Practices for Better Healthcare: A Consensus Report*, Washington, DC: NQF; 2003.
- 241 NQF, *Implementing a National Voluntary Consensus Standard for Informed Consent: A User's Guide for Healthcare Professionals*, Washington, DC: NQF; 2005.
- 242 NQF, *National Framework and Preferred Practices for Palliative and Hospice Care: A Consensus Report*, Washington, DC: NQF; 2006.



# Appendix A

## A Cultural Competency Framework for Quality Measurement and Reporting

**Robert Weech-Maldonado, Ph.D.**

Associate Professor

Department of Health Services Research, Management and Policy

University of Florida

This paper has been edited for minimal stylistic consistency. The content and accuracy of the paper are the responsibility of the author, not the National Quality Forum.

**Acknowledgment:** The author is grateful to the Cultural Competency Quality Steering Committee and the National Council for Healthcare Leadership project staff for comments on earlier drafts of this paper. The author also acknowledges the capable research assistance of Silvia Menendez, Justin Krueger, and Rohit Pradhan at the University of Florida.

## Purpose

The Institute of Medicine<sup>1</sup> in its report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* documents the existence of racial and ethnic disparities in access to health care, as well as poorer outcomes and health status among racial and ethnic minorities. Among the strategies advocated for reducing disparities in health care is the provision of “culturally competent” care.<sup>2</sup>

The Office of Minority Health’s<sup>3</sup> publication of standards for culturally and linguistically appropriate services (CLAS) for health care organizations (HCOs) has been a major catalyst in the development of various frameworks for cultural competence measurement.<sup>4,5</sup> Despite these efforts, consensus on a specific measurement and reporting framework is lacking. In order to advance the field, national voluntary consensus on critical competencies for measuring and reporting the quality of culturally competent care is needed. From these competencies, preferred practices and performance measures can be developed and endorsed.<sup>6</sup>

The objectives of the paper are to propose: 1) a definition of “cultural competency” in the health care context; 2) overarching guiding principles in assessing cultural competency; and 3) a framework for measuring cultural competency that can be used across the spectrum of health care settings.

## Culture and Cultural Competency

Culture can be viewed as an “integrated pattern of learned beliefs and behaviors” shared by individuals of a group that can affect styles of communication, interpersonal relationships, values, and customs.<sup>7</sup> Various sociocultural factors, such as race/ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation can influence the cultural background of an individual.

Culture is central in the delivery of health care services, since it can influence patients’ health beliefs, medical practices, attitudes towards medical care, and levels of trust.<sup>3,8</sup> Cultural differences can ultimately impact how health information is received, understood, and acted upon.<sup>9</sup> Clinical barriers occur when cultural differences are not adequately addressed in health care delivery, resulting in lower access and quality of care for culturally diverse populations. As such, addressing cultural differences becomes imperative, and health care organizations are espousing cultural competency as an organizational strategy.

Brach and Fraser<sup>10</sup> have proposed a model whereby cultural competency practices can ultimately result in a reduction of health disparities. In this model, cultural competency practices can influence the behavior of clinicians and patients, and bridge cultural gaps. This, in turn, can improve the likelihood of diverse populations receiving appropriate services and experiencing improved outcomes and a reduction in health disparities (Figure 1). For example, cultural competency can reduce barriers in clinician-patient communication, which in turn can improve access to care and ultimately outcomes of care.<sup>9</sup>



**Figure 1: Reducing Health Disparities through the Implementation of Cultural Competency**



Source: Brach and Fraser<sup>10</sup>

One of the major organizational barriers for cultural competency is the perceived impact it may have on costs. However, Brach and Fraser<sup>11</sup> have argued the business case for cultural competency. In their view, HCOs have four interrelated financial incentives for cultural competency. First, by becoming culturally competent, HCOs can increase their appeal to diverse populations, and increase their market share. This is particularly critical as the population becomes increasingly diverse. Second, cultural competence can improve the performance of HCOs in quality measures that are monitored by private purchasers, which can be particularly important in competitive markets with a large diverse population. Third, increasingly public purchasers, such as Medicaid and Medicare, are instituting cultural competency requirements in their contracts. HCOs must comply with these requirements to maintain their contracts with said public purchasers. Fourth, cultural competency has the potential to reduce costs by reducing unnecessary diagnostic testing, inappropriate use of services, and medical errors.

To date, relatively few studies have assessed the extent of cultural competency and diversity management practices of HCOs in the United States.<sup>12,13</sup> Weech-Maldonado and colleagues<sup>12</sup> found that hospitals in Pennsylvania have been relatively inactive with respect to cultural competency practices, and that equal employment requirements are the main driver of diversity management policy. The number and scope of cultural competency practices used were not influenced by organizational or market characteristics. A recent study of Alabama hospitals shows that while hospitals have taken initial steps to prepare for the diversifying patient population, there is still a lot more work that needs to be done before they meet the CLAS standards.<sup>13</sup>

## **Towards a Definition of Cultural Competency**

While the case has been made for cultural competency from a clinical and business standpoint, the major challenge remaining is how to define and assess cultural competency. Various definitions exist on cultural competency (Table 1). One distinguishing characteristic of these definitions is the unit of analysis. While some definitions have focused on the individual or clinician level,<sup>14,15</sup> others have focused on the organizational level.<sup>3,6,7,16</sup> Yet other definitions recognize both the individual and organizational aspects of cultural competency.<sup>3,16</sup>

**Table 1. Definitions of Cultural Competence**

Author	Definition	Citation
Betancourt et al. 2002: V 7	“The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs”	Curtis et al. 2007 <sup>27</sup> Larson 2005 <sup>69</sup>
Betancourt et al. 2003: 297 <sup>8</sup>	“Understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations”	
Brach and Fraser 2000: 183 <sup>10</sup>	“An ongoing commitment or institutionalization of appropriate practice and policies for diverse populations”	Curtis et al. 2007 <sup>27</sup> Dreachslin and Myers 2007 <sup>28</sup> Weech-Maldonado et al. 2002 <sup>12</sup>
Cooper and Roter 2003: 554 <sup>14</sup>	“The ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences”	
Cross et al. 1989: 13 <sup>17</sup>	“A set of congruent behaviors, attitudes, and policies, that come together in a system, agency, or among professionals, and enable effective work in cross-cultural situations”	Anderson et al. 200 <sup>39</sup> Brach and Fraser 2000 <sup>10</sup> Brach et al. 2006 <sup>32</sup> Hobgood et al. 2006 <sup>62</sup> Lewin Group 2002 <sup>4</sup> Moxley et al. 2004 <sup>70</sup> Ngo-Metzger et al. 2006 <sup>2</sup> Wilson-Stronks and Galvez 2007 <sup>35</sup> Zambrana et al. 2004 <sup>71</sup>
MCF 2004 <sup>72</sup>	“The ability to transform knowledge and cultural awareness into health and/or psychosocial interventions that support and sustain healthy client-system functioning within the appropriate cultural context”	
Kim-Godwin et al. 2001: 920 <sup>59</sup>	“A complex integration of cultural knowledge, cultural awareness or sensitivity, attitudes, cultural skills, and cultural encounters”	

*more*

**Table 1. Definitions of Cultural Competence**

Author	Definition	Citation
OMH 2001: 5 <sup>3</sup>	“Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities”	Anderson et al. 2003 <sup>9</sup> Hobgood et al. 2006 <sup>62</sup>
Romeo 2007: 206 <sup>16</sup>	“A learning process that enables individuals and organizations to function effectively in the midst of cultural difference”	
Sandars and Ewart 2005: 2 <sup>15</sup>	“A set of behaviors and attitudes that enable professionals to work effectively in cross-cultural situations”	
Schim et al. 2007 <sup>73</sup>	“A behavioral construct encompassing actions taken in response to cultural diversity, awareness, and sensitivity”	
Williams 2007: S55 <sup>74</sup>	“A set of academic, interpersonal, and clinical skills developed to help individuals increase their understanding of differences and similarities within, among, and between groups”	

All the definitions seem to agree on an ultimate outcome for cultural competency: to improve health care delivery for diverse populations. However, some of these definitions focus on the structural aspects of cultural competency, such as having the capacity or ability to address the health care needs of diverse patient populations,<sup>3,7</sup> while others describe cultural competency as a process.<sup>16</sup> Yet other definitions use a combination of structural and process aspects, describing it as a set of behaviors, attitudes, or both.<sup>17</sup>

In proposing a definition of cultural competence, we attempted to address both the individual and organizational aspects of cultural competency as well as the structural and process elements of cultural competency:

*Cultural competency is the ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient populations high-quality care that is patient- and family-centered and equitable.*

Cultural competency is achieved through policies, learning processes, and structures by which organizations and individuals develop the attitudes, behaviors, and systems that are needed for effective cross-cultural interactions, including but not limited to socio-cultural factors such as race/ethnicity, nationality, language, gender, socioeconomic status (SES), immigrant status, physical and mental ability, sexual orientation, religion, health literacy, age, and occupation.<sup>8</sup> These factors can be conceptualized as cultural group identities. Individuals’ affiliations to cultural groups are complex, with individual differences based on the group identity profile and strength

of the group identities.<sup>18</sup> For example, a second-generation Hispanic of higher SES will differ from a recent immigrant Hispanic of lower SES in terms of his or her group identity profile as well as the strength of the group identities. These differences will affect an individual's interactions with the health care system.

High-quality care implies state-of-the-art care based on evidence-based clinical practices. According to the Institute of Medicine's (IOM's)<sup>19</sup> "equity" aim for health system improvement, quality of care should not differ because of socio-cultural factors. Family centeredness implies respecting the desire of culturally diverse groups to include their family members in health care decision making.<sup>10</sup> The care is patient-centered when clinicians treat each patient as an individual, within the context of his or her care.<sup>20,21</sup> This requires a partnership among clinicians, patients, and families to ensure that health care decisions take into account patient preferences.

## **Guiding Principles for Cultural Competency**

Guiding principles for measuring and reporting cultural competency quality provide broad themes and direction that promote standardized measurement and reporting, drive practice improvement and measure development, and support implementation. The guiding principles are intended to be overarching and/or cross-cutting all (or multiple) domains of the framework presented in the next section. There are five principles that guide the development of the proposed cultural competency framework.

### **Principle 1. Multi-Level Approach**

*Cultural competency should be viewed as a multi-level approach with assessments and interventions needed at the system, provider organization, group, and individual levels.*

Cultural competence has generally been viewed as pertinent to individual clinical interactions. However, this view fails to recognize that "clinicians will become culturally competent only with the support and/or encouragement of the health systems in which they participate."<sup>10</sup> "Cultural competence should be considered as much of a function of the organization as it is a result of the interactions between providers and patients."<sup>22</sup>

Four levels of care can be identified with each requiring a different set of measures of and interventions for cultural competency: 1) system—as represented by a health care or managed care entity that oversees a number of owned or affiliated provider organizations; 2) provider organization—the entities that provide direct services to the patient, such as clinics, hospitals, or nursing homes; 3) group—includes formal departmental and cross-departmental teams; and 4) individual—people involved directly or indirectly in the delivery of care.<sup>5,23</sup>

### **Principle 2. Viewed as a Process and Continuum**

*Cultural competency should be viewed as an ongoing process of organizational transformation in a continuum from early to later stages of development.*

For health care organizations to become more culturally competent they will need to engage in a change process of organizational transformation. This entails an organizational culture change from a monoculture, or culture that "accepts only one way of doing things and one set of values

and beliefs” to a pluralistic environment, or an environment that accepts and integrates people from diverse cultural backgrounds.<sup>24</sup>

This change process has been described as a continuum from early to later stages of development. For example, Tirado<sup>25</sup> proposes a five-stage model of organizational change: culturally resistant, culturally unaware, culturally conscious, culturally insightful, and culturally versatile. Similarly, Dreachslin<sup>26</sup> proposes a five-stage change model from affirmative action to valuing diversity: discovery, assessment, exploration, transformation, and revitalization.

### **Principle 3. Systems Approach**

*Successful implementation of cultural competency initiatives to achieve high-quality, culturally competent care requires an organizational commitment towards a systems approach.*

Successful implementation of cultural competency requires an organizational commitment towards a systems approach.<sup>27,28</sup> In this approach, the HCO is viewed as a system comprised of interrelated and interdependent subsystems, such as patient care, ancillary services, professional staff, financial, informational, physical, and administrative subsystems.<sup>29</sup>

Related to systems thinking is the open systems perspective that views organizations interacting with their environment to secure resources, process them, and produce some type of output. To survive, it is critical that organizations respond to the demands of their environment to ensure a continuous inflow of resources.<sup>30</sup> For HCOs, the community is the major resource supplier. Therefore, HCOs have to adapt to the changing community needs to ensure their survival.

Cultural competency should not be conceived as a stand alone, point-in-time effort pertinent only to clinical interactions. Rather, HCOs should strive towards a systems approach where cultural competency practices are integrated throughout their management and clinical sub-systems. Furthermore, HCOs should engage their communities in meaningful participation in the organization’s decision-making and power structures.

### **Principle 4. Diversity Management**

*Addressing both organizational and clinical aspects in managing diversity and the needs of both a diverse workforce and patient population are important factors in culturally competent care.*

The cultural competency and diversity management literatures have had different focuses with respect to diversity issues. The cultural competency literature has had a clinical orientation with a focus on patient-clinician interactions, while the diversity management literature has had an organizational orientation with a focus on workforce issues. However, these differences are becoming increasingly less distinct as both camps agree on the importance of both to cultural competency.<sup>12</sup> For example, it is increasingly recognized that organizations need strategies aimed at recruiting and retaining a diverse workforce, as well as staff training and development in cross-cultural communication skills to enhance cultural competency.

## Principle 5. Continuous Improvement

*Cultural competency should not be viewed as an endpoint but rather organizations should strive for continuous improvement.*<sup>31</sup>

Continuous improvement in cultural competency represents an ongoing process whereby organizations: 1) determine cultural competency goals in the context of its strategic plan; 2) assess individual, group, and organizational baseline performance to determine gaps in performance; 3) develop interventions to close the gaps in performance; and 4) reassess performance to determine the effectiveness of the interventions. For example, in designing cultural competency training, the organization should determine goals for its training in the context of its strategic plan, measure current performance against needs, design training to address the gap, implement the training, assess training effectiveness, and strive for continuous improvement.<sup>27</sup>

## Framework for Measuring and Reporting Cultural Competency Quality

Standardized measurement and reporting of cultural competency requires identification of a comprehensive framework that delineates the domains and sub-domains that comprise high-quality, culturally competent care. The framework consists of seven domains of cultural competency and their respective sub-domains (Table 2). From this framework, preferred practices can be identified and/or mapped to, and from those practices, measures can be developed.

### Domains

Seven primary domains are recommended:

1. **Leadership** recognizes that organizational leaders, including clinical leaders, administrative leaders, and the Board of Trustees, play an essential role in developing and implementing cultural competency activities, in setting organizational policy and strategy, and in monitoring organizational performance.
2. **Integration into Management Systems and Operations** focuses on whether cultural competency is integrated throughout all management practices of the organization.
3. **Patient-Provider Communication** addresses all communication between the patient and clinicians as well as support staff.
4. **Care Delivery and Supporting Mechanisms** encompasses the delivery of care, the physical environment of where the care is delivered, and links to supportive services and providers.
5. **Workforce Diversity and Training** can be viewed as a means to providing more effective services for culturally diverse populations via human resource proactive recruitment and retention strategies to ensure diversity at all levels of the organization, and it also relates to whether training and development activities include state-of-the-art content in cultural competency and reflect organizational commitment towards cultural competency.
6. **Community Engagement** refers to active outreach, as well as community inclusion and partnership in organizational decision making.

**Table 2. Framework for Measurement and Reporting of Cultural Competency**

Domain	Sub-domains
Leadership	Commitment to Diversity Organizational Culture Leadership Diversity Dedicated Staff and Resources Policies Training and Development
Integration into Management Systems and Operations	Strategic Planning Performance Evaluation Reward Systems Service Planning Marketing Public Relations
Patient-Provider Communication	Interpreter Services Translation Services Health Literacy Strategies Knowledge of Culture and Social Context Cultural Awareness Cross-Cultural Communication Skills Family Centeredness
Care Delivery and Supporting Mechanisms	Physical Environment Assessment Tools Coordination of Care Linkages with Alternative Medicine Providers Linkages with Community Based Organizations Health Information Technology
Workforce Diversity and Training	Recruitment Retention Training Commitment Training Content
Community Engagement	Community Outreach Community-Based Participatory Research Community Representation in Organizational Decision Making Community Investments
Data Collection, Public Accountability, and Quality Improvement Information	Collection of Patient Cultural Competence-Related Information Assessment of Patient Experiences with Care Documentation of Cross-Cultural Complaints and Resolutions Documentation of Cultural Competency Practices Collection of Community Cultural Competence-Related Performance Management Systems Self-assessments of Cultural Competence Quality Improvement

**7. Data Collection, Public Accountability, and Quality Improvement** means whether the organization collects data necessary to assess its cultural competency, whether it performs routine self-assessments in this regard, and whether it integrates cultural competency into its public accountability and quality improvement activities.

## **Sub-domains**

Each of the seven proposed domains also includes specific sub-domains that further articulate the core competencies of high-quality, culturally competent care, as follows:

### **1. Leadership**

- a. **Commitment to Diversity**—cultural competency activities are most effective when the organization’s governing board and top management embrace cultural competence and communicates this support throughout the organization.<sup>32,33</sup>
- b. **Organizational Culture**—a culture that is inclusive and values cultural differences. Organizational leaders are instrumental in setting organizational culture.<sup>34</sup> Inclusive signifies that the organization’s decision-making processes include diverse points of views from within and outside the organization. When an organization values diversity it is shown through its practices, structures, and policies.
- c. **Leadership Diversity**—leadership at all levels of the organization, including the Board of Trustees, reflects the community diversity.<sup>4</sup> Leadership diversity increases the likelihood that the needs of a diverse workforce and patient population are taken into account in organizational decision-making processes.<sup>9</sup> However, minorities have traditionally faced barriers, or a “glass ceiling” effect, that have excluded them from upper management positions.<sup>18</sup> As such, HCOs need proactive human resource strategies aimed at diversifying the leadership ranks and breaking the glass ceiling.
- d. **Dedicated Staff and Resources**—an organization shows its commitment to cultural competency by dedicating resources and designating staff for cultural competency activities. Dedicated resources can be shown by budgeting resources for cultural competency activities.<sup>4,35</sup> Dedicated staff can include an executive-level staff member, department, or office that focuses on multicultural and/or linguistic issues. This can be instrumental in coordinating organization-wide initiatives and monitoring progress towards cultural competency goals.<sup>32,35</sup>
- e. **Policies**—formal policies that address cultural competency issues, such as recruitment and retention of a diverse workforce, language services, and training and development.<sup>4,35</sup> Policies “express an organization’s intentions and provide a blueprint for action.”<sup>36</sup> These internal policies should be in conformity with external regulatory and statutory policies.
- f. **Training and Development**—training and development of leaders at all levels of the organization, including the Board of Trustees, on cultural competency issues.<sup>4</sup> Leadership participation in training and development sends a signal to organizational members of its commitment to cultural competency.



## 2. Integration into Management Systems and Operations

- a. Strategic Planning—the strategic planning process includes environmental scanning, asset and needs assessment of the communities served, and formulation of goals related to cultural competency.<sup>3</sup> Strategic goals reflect the organizational priorities for resource use and deployment.
- b. Performance Evaluation—job descriptions and performance evaluation systems include criteria related to cultural competency.<sup>3,4</sup> This evaluation process should include assessments of patient and family experiences with care. This results in accountability for meeting cultural competency goals.
- c. Reward Systems—managers and staff are rewarded for meeting cultural competency goals.<sup>4</sup> Incentives help align the organizational members’ goals with those of the organization. Thorndike’s law of effect states that behavior or performance that is reinforced tends to be repeated.<sup>37</sup>
- d. Service Planning—organizations design their services taking into account the needs of their diverse patient populations. This includes all elements of the health care encounter from admission to discharge with the ultimate goal of improving access to care for all patients.<sup>8</sup> Examples include expanding clinical hours to accommodate community work patterns, adapting to ethnic or religious dietary preferences, and allowing for large families visiting or staying with hospitalized patients.<sup>8,35</sup>
- e. Marketing—organizations promote and market their services through a variety of media that reaches out to diverse populations, including ethnic newspapers, television news programs, and radio stations.<sup>35</sup> Marketing also should emphasize the availability of language services, such as interpretation and translation services. A related concept is that of social marketing where HCOs use marketing principles to design a social-change strategy aimed at reducing high-risk behaviors or encouraging healthy behaviors.<sup>38,39</sup> An example of social marketing is using the media for a public health campaign to reduce smoking.
- f. Public Relations—raise public awareness of cultural competency activities and progress in meeting goals.<sup>3,4</sup> This can include a statistical annual report on patient demographics, interpreter use and availability, translated materials, staff training in cultural competency, and survey results of patient experiences with care. This can serve as a marketing tool while enhancing the organization’s image among diverse communities.

## 3. Patient-Provider Communication

- a. Interpreter Services—high-quality interpreter services are needed at all points of patient contact to improve provider and staff communication with patients of limited English proficiency. Accurate communication increases the likelihood of receiving appropriate care.<sup>3,9,35</sup> Language concordant encounters have better communication, interpersonal processes, and outcomes than language discordant encounters.<sup>40-44</sup> However, the limited supply of bilingual providers has led health care organizations to use interpreter services to bridge language gaps. When evaluating the quality of interpreter services, it is important to distinguish between professional and ad-hoc interpreters.<sup>2</sup> Ad-hoc interpreters are “individuals whose primary job function in the health care setting is something other than interpretation and includes the patient’s family members, friends, clinic staff, or even fellow patients.”<sup>45</sup> On the other hand, professional interpreters are “those individuals whose sole function in the health

care setting is to interpret.”<sup>45</sup> Prior research has shown the effectiveness of professional interpreters compared to ad-hoc interpreters.<sup>46-48</sup> Professional interpreter services may be in-person or remote. Remote interpreter services include telephone language lines, video links, and other remote systems. Regardless of the type of interpreter used, interpreters should have proficiency in both languages, mastery of medical terminology in both languages, memory skills, ability to negotiate a three-way conversation, and basic knowledge of cultural aspects that can influence health. Bilingual providers should be proficient in the target language, including knowledge of medical terminology.<sup>2</sup>

- b. Translation Services—patient-related written materials are translated into the most common languages of the patient population.<sup>3,4</sup> Examples of relevant patient-related materials include applications, consent forms, preventive and treatment instructions, and patient education materials. Translated materials should be evaluated for linguistic and cultural appropriateness with respect to both content and context.<sup>49</sup> Linguistically appropriate translated materials are conceptually and technically equivalent to the source language. Technical equivalence refers to similarity in grammar and syntax, while conceptual equivalence refers to the absence of differences in meaning and content between the source and translated documents. Weidmer et al. have proposed a translation process that involves: 1) obtaining two independent forward translations; 2) conducting a review of translation by a separate bilingual reviewer; and 3) reconciling translations by committee (forward translators and bilingual reviewer) consensus.<sup>50</sup> Culturally appropriate translated materials reflect the cultural assumptions, norms, values, and expectations of the target population.<sup>51</sup> Qualitative methods, such as focus groups and cognitive interviews, are particularly useful in assessing the cultural appropriateness of translated materials.<sup>49</sup>
- c. Health Literacy Strategies—addressing the literacy needs of the patient in both oral and written communication.<sup>2</sup> Healthy People 2010 defines health literacy as the “degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.”<sup>52</sup> People with low health literacy tend to have more problems with both written and oral communication.<sup>53</sup> Several strategies have been suggested for health care professionals to improve oral and written communication with low literacy patients:<sup>54-56</sup> 1) avoid use of medical jargon, and instead use commonly understood words; 2) use audiovisual aids to supplement oral and written instructions; 3) include interactive instructions by making patients do, write, say, or show something to demonstrate their understanding (teach back method); 4) write materials at a sixth-grade level or lower; and 5) pretest materials to evaluate whether materials are suitable for the intended audience.
- d. Knowledge of Culture and Social Context—having the knowledge base of cultural groups with respect to traditional healing practices, health-related beliefs and cultural values, disease incidence, prevalence and outcomes, as well as health disparities.<sup>57-60</sup> This knowledge should include also an awareness of the historical context that may explain the way different groups interact with the health care system.<sup>8</sup> One example is the relationship between the Tuskegee Syphilis Study and mistrust of health care professionals among African Americans. However, care must be exercised that this cultural knowledge does not lead to or reinforce stereotyping.<sup>8</sup> Rather this knowledge should be used in the context of patient-centered care and effective cross-cultural communication skills.<sup>61</sup>

- e. Cultural Awareness—self-examination and exploration of one’s own cultural background. This includes an awareness of our own assumptions, biases, stereotypes, and prejudices with respect to individuals from other cultures.<sup>58-60</sup>
- f. Cross-Cultural Communication Skills—this includes skills to obtain culturally relevant data, such as those used in conducting cultural assessments and culturally based physical assessments.<sup>58-60,62</sup> It also includes skills needed in “identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism.”<sup>8</sup> Patient-centered cross-cultural communication makes the patient a primary source of cultural knowledge and an active participant in the patient-doctor negotiation.
- g. Family Centeredness—respecting the desire of culturally diverse groups to include their family members in health care decision making.<sup>10</sup>

#### 4. Care Delivery and Supporting Mechanisms

- a. Physical Environment—this includes culturally sensitive design and architecture, physical environments, where the décor, artwork, posters, and literature reflects the diversity of the service area.<sup>4</sup> It also includes appropriate signage in the major languages spoken in the service area.<sup>3</sup>
- b. Assessment Tools—use of tools to elicit culturally relevant information on health beliefs, behaviors, and practices.<sup>4</sup> These data can be used to assist with establishing a physical environment and care delivery that are culturally appropriate for the community served.
- c. Coordination of Care—includes documenting and tracking referrals to other health care services in the continuum of care (from ambulatory to long-term care), and ensuring that information on patients’ cultural and linguistic needs is shared with other health care providers. Coordination of care includes managing the transition back to home, nursing home, or other institutional care, and supporting palliative and end of life care.
- d. Linkages with Alternative Medicine Providers—identifying patients’ use of alternative providers and coordinating with these providers to augment allopathic treatments and avoid complications due to incompatible therapies.<sup>10</sup>
- e. Linkages with Community-Based Organizations—understanding and addressing the context of the patient (e.g., socioeconomic status, supports/stressors, environmental hazards) as an important element of cultural competence.<sup>4,8</sup> It is important to identify community-based organizations, such as human, social service, and religious organizations, and coordinate with them to assist with care delivery.
- f. Health Information Technology—new information technologies, such as electronic and personal medical records, should be used to enhance and promote the delivery of culturally competent care.

## 5. Workforce Diversity and Training

- a. Recruitment—human resource practices aimed at diversifying the workforce at all levels of the organization.<sup>4</sup> Racial/ethnic and language concordance between patient and provider has been associated with better patient experiences with care and satisfaction.<sup>2,8</sup> However, the current demographics of the health professions do not correspond to the composition of the general workforce. For example, while African Americans and Hispanics account for about 25 percent of the workforce, fewer than 12 percent of physicians and therapists, and only 15 percent of registered nurses are from these two racial/ethnic groups.<sup>36</sup> This calls for proactive recruitment strategies that will result in a more diverse applicant pool. As such, organizations “need to find alternatives to generic newspaper advertisements, search firms, and other mainstream recruiting methods. Community-based and national health organizations and networks as well as publications and search firms that target diverse populations may provide better channels for recruiting and advertising vacancies.”<sup>3</sup> Furthermore, organizational efforts aimed at improving the diversity of the workforce pipeline are needed. This may include partnerships with local elementary and secondary schools, particularly those with a high percentage of racial/ethnic minorities, to increase their interest in the health care professions.
- b. Retention—organizational efforts need to go beyond recruitment strategies and include retention strategies. Otherwise organizations can become a “revolving door” for diverse employees, as they leave the organization in pursuit of better opportunities or a more welcoming environment. Retention strategies include efforts to create a welcoming climate for diverse populations, identifying barriers that prevent employees from achieving their full potential, and providing equitable promotional opportunities.<sup>3,9</sup> Formal mentoring programs, professional development and training, work-life balance and flexible benefits, and affinity groups are among the human resource retention strategies that can be used.<sup>36</sup>
- c. Training Commitment—organizations need to ensure that managers and staff at all levels of the organization receive appropriate and ongoing training in cultural competency.<sup>3,4</sup>
- d. Training Content—staff training curriculum should emphasize the knowledge and skills as outlined under the 1) patient-provider communication and the 2) care delivery and supporting domains.<sup>4,9</sup> In addition, staff training should include strategies to assist a diverse staff with relating to each other. Leadership training should include content from all seven domains of cultural competence. Cultural competency training can be delivered as a stand-alone program or it can be integrated into other training programs. Formal training can be complemented with less formal activities that develop staff knowledge about cultures and languages in their hospital, such as cultural fairs and reading clubs focused on specific cultures or languages.<sup>35</sup> These trainings should be conducted by qualified staff that are trained in cultural competence, and should be periodically updated and repeated. The trainings should be assessed for effectiveness and relevance in meeting the cultural needs of patients.

## 6. Community Engagement

- a. Community Outreach—this includes collaborative relationships and partnerships with community entities to understand and address the cultural and linguistic needs of the communities served.<sup>35,63</sup> It may also include liaisons, such as community health workers where members of minority communities are used to reach out to those communities.<sup>4,10</sup> For example, community health workers that are trained to teach others with the same chronic conditions about disease self-management.

- b. Community-Based Participatory Research—actively engage in community-based participatory research (CBPR), which has been defined as a “collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.”<sup>64</sup> By engaging in CBPR, HCOs enable the generation of actionable knowledge that can be used to address the most pressing health needs of the populations served.<sup>65</sup>
- c. Community Representation in Organizational Decision Making—using formal and informal mechanisms for community involvement, such as community advisory groups or committees in service planning and implementation.<sup>3,4</sup>
- d. Community Investments—organizations should invest in both the infrastructure and human capital of the communities served, and should take into account the community assets in its outreach, education, and information gathering activities.

## 7. Data Collection, Public Accountability, and Quality Improvement

- a. Collection of Patient Cultural Competence-Related Information—mechanisms for collecting data on cultural subgroups, such as race/ethnicity, language preferences, education, and income of patients; and integrating these data into the information systems.<sup>3,4</sup> These data are important for strategic and service planning and can be used to monitor health care disparities as well as for quality improvement.<sup>7</sup> The Joint Commission now requires collection of patients’ language and communication needs in the patient record.<sup>35</sup>
- b. Assessment of Patients’ Experiences with Care—assess patients’ experiences with care in their own language using qualitative and quantitative methods. Patients’ assessments of care are critical because they capture firsthand experiences as patients interact with the health care system. The Consumer Assessments of Healthcare Providers and Systems (CAHPS) is a set of standardized survey instruments that assess patient experiences with care across provider settings. Prior research using CAHPS data has shown racial/ethnic and language differences in patients’ experiences with care.<sup>66,67</sup> Focus groups and personal interviews are qualitative methods that can complement quantitative assessments, such as CAHPS, by providing more in-depth information on the observed cultural differences in patient experiences with care. These data can be used for quality improvement purposes.<sup>7</sup>
- c. Documentation of Cross-Cultural Complaints and Resolutions—having in place mechanisms to identify and resolve cross-cultural conflicts or complaints by patients.<sup>3</sup> Individuals from diverse backgrounds are more vulnerable to face experiences where their cultural differences are not accommodated or respected by the HCO. Some of the mechanisms that HCOs can adopt to identify and resolve cross-cultural conflicts are: “providing cultural competence training to staff who handle complaints and grievances or other legal or ethical conflict issues; providing notice in other languages about the right of each patient/consumer to file a complaint or grievance; providing the contact name and number of the individual responsible for the disposition of a grievance; and offering ombudsperson services.”<sup>3</sup>
- d. Documentation of Cultural Competency Practices—mechanisms to document the delivery of culturally competent care services, such as the provision and timeliness of language services, workforce diversity, and referrals to alternative medicine providers and community-based organizations. This information is important for on-going self-assessments of cultural competency, as well as for public reporting of such activities.

- e. Collection of Community Cultural Competence-Related Information—this includes maintaining a current demographic, cultural, socioeconomic, and epidemiological profile and needs assessment of the communities served and using the data for strategic planning purposes, quality improvement, and public reporting initiatives.<sup>3,4,35</sup>
- f. Performance Management Systems—include cultural competence-related measures in the organizational performance management systems, such as balanced score cards, organizational climate surveys, adverse events reports, and outcomes-based evaluations.<sup>3,35</sup> Examples of metrics that can be incorporated are patient and human resource outcomes for different cultural groups. Including these measures in performance management systems elevates their importance for the institution.<sup>28</sup>
- g. Self-assessments of Cultural Competence—organizations should conduct ongoing self-assessments of their progress in meeting cultural competence goals.<sup>3</sup> Assessments are needed at all four levels of care: system, provider organization, group, and individual.<sup>8</sup> System and provider organizational-level assessments provide a picture of the organization’s readiness towards cultural competency by examining its structures, policies, and practices. Group-level assessments can provide a gauge of organizational culture and climate. Individual-level assessments can assess cultural competency and cross-cultural skills at the individual level.
- h. Quality Improvement—organizations integrate cultural competence into their quality improvement (QI) activities. QI can be viewed as an organization-wide approach to planning and implementing continuous improvement in performance. As such, QI “emphasizes continuous examination and improvement of work processes by teams of organizational members trained in basic statistical techniques and problem solving tools and empowered to make decisions based on the analysis of data.”<sup>68</sup> Health care organizations can use QI activities to address health disparities in access, outcomes, or patient experiences with care.

## Conclusion

The Office of Minority Health’s CLAS standards have been a major catalyst in the development of various frameworks for cultural competence measurement. Despite these efforts, consensus on a specific measurement and reporting framework has been lacking. Standardized measurement and reporting of cultural competency requires identification of a comprehensive framework that delineates the core competencies that comprise high-quality, culturally competent care. This paper achieved three major goals. First, we proposed a definition of cultural competence that addresses both the individual and organizational aspects of cultural competency, as well as the structural and process elements of cultural competency in health care. Second, we established five guiding principles that are intended to be overarching and/or cross-cutting all (or multiple) domains of the proposed framework. Finally, we proposed a framework consisting of seven core competencies or domains of cultural competency: 1) leadership; 2) integration into management systems and operations; 3) patient-provider communication; 4) care delivery and supporting mechanisms; 5) workforce diversity and training; 6) community engagement; and 7) data collection, public accountability, and quality improvement. Each of the seven proposed domains also includes specific sub-domains that further articulate the core competencies of high-quality, culturally competent care. From this framework, preferred practices and performance measures can be developed and endorsed by the National Quality Forum.

## References

1. Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, Smedley BD, Stith AY, Nelson AR, eds., Washington DC: The National Academies Press; 2003.
2. Ngo-Metzger Q, Telfair J, Sorkin DL, et al., *Cultural Competency and Quality of Care: Obtaining the Patient's Perspective*, New York: The Commonwealth Fund; 2006.
3. Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, DC: Department of Health and Human Services; Office of Minority Health; 2001.
4. Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence: Assessment Profile*, Falls Church, VA: The Lewin Group; 2002.
5. Siegel C, Haugland G, Chambers ED, Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery, *Adm Policy Ment Health*, 2003;31(2):141-170.
6. National Quality Forum, *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*, Washington, DC: National Quality Forum; 2009.
7. Betancourt JR, Green AR, Carrillo JE, et al., *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, New York: The Commonwealth Fund; 2002.
8. Betancourt JR, Green AR, Carrillo JE, et al., Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care, *Public Health Rep*, 2003;118(4):293-302.
9. Anderson LM, Scrimshaw SC, Fullilove MT, et al., Culturally competent healthcare systems: A systematic review, *Am J Prev Med*, 2003;24(3):68-79.
10. Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model, *Med Care Res Rev*, 2000;57:187-217.
11. Brach C, Fraser I, Reducing disparities through culturally competent health care: An analysis of the business case, *Qual Manag Health Care*, 2002;10(4):15-28.
12. Weech-Maldonado R, Dreachslin JL, Dansky KH, et al., Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals, *J Healthc Manag*, 2002;47(2):111-124.
13. Whitman M, Davis J, Cultural and linguistic competence in healthcare: The case of Alabama general hospitals, *J Healthc Manag*, 2008;53(1):26-39.
14. Cooper LA, Roter DL, Patient-Provider Communication: The Effect of Race and Ethnicity on Process and Outcomes of Healthcare, In: Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, Smedley BD, Stith AY, Nelson AR, eds., Washington DC: The National Academies Press; 2003.
15. Sanders J, Ewart B, Developing cultural competence for healthcare leaders through work based learning, *Work-Based Learning in Primary Care*, 2005;3:99-105.
16. Romeo C, Caring for culturally diverse patients: One agency's journey toward cultural competence, *Home Health Nurse*, 2007;25(3):206-213.
17. Cross TL, Bazron BJ, Dennis KW, et al., *Towards a Culturally Competent System of Care Vol I: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*, Georgetown, MD: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center; 1989.
18. Cox T, *Cultural Diversity in Organizations: Theory, Research & Practice*, San Francisco, CA: Berrett-Koehler; 1994.
19. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: Institute of Medicine, Committee on Quality Health Care in America; 2001.
20. Carrillo JE, Green AR, Betancourt JR, Cross-cultural primary care: A patient-based approach, *Ann Intern Med*, 1999;33(10):829-834.
21. Markova T, Broome B, Effective communication and delivery of culturally competent health care, *Urol Nurs*, 2007;27(3):239-242.
22. California Pan-Ethnic Health Network, *Diverse Patients, Disparate Experience: The Use of Standardized Patient Satisfaction Surveys in Assessing the Cultural Competence of Health Care Organizations*, Oakland, CA: California Pan-Ethnic Health Network; 2001.
23. Shortell SM, Kalunzy DA, *Health Care Management: Organization Design & Behavior*, New York: Thomson Delmar Learning; 1999.
24. Daft LR, Marcic D, *Understanding Management*, Chula Vista, CA: South-Western College Publication; 2005.

25. Tirado M, *Monitoring the Managed Care of Culturally and Linguistically Diverse Populations*, Washington, DC: The National Clearinghouse for Primary Care Information; 1998.
26. Dreachslin JL, *Diversity Leadership*, Chicago, IL: Health Administration Press; 1996.
27. Curtis EF, Dreachslin JL, Sinioris M, Diversity and cultural competency training in health care organizations: Hallmarks of success, *Health Care Manag*, 2007;26(3):255-262.
28. Dreachslin JL, Myers VL, A systems approach to culturally and linguistically competent care, *J Healthc Manag*, 2007;42(4):220-226.
29. Longest BB, Rakich SJ, Darr K, *Managing Health Services Organizations and Systems*, Baltimore, MD: Health Professions Press; 2000.
30. Scott WR, Davis GF, *Organizations and Organizing: Rational, Natural and Open System Perspective*, Upper Saddle River, NJ: Pearson/Prentice Hall; 2007.
31. Campinha-Bacote J, Yahle T, Langenkamp M, The challenge of cultural diversity for nurse educators, *J Contin Educ Nurs*, 1996;27(2):59-64.
32. Brach C, Paez K, Fraser I, *Cultural Competence California Style*, Rockville, MD: Agency for Healthcare Research and Quality; 2006.
33. Dansky KH, Weech-Maldonado R, De Souza G, et al., Organizational strategy and diversity management: Diversity sensitive orientations as a moderating influence, *Health Care Manage Rev*, 2003;28(3):243-253.
34. Muller HJ, Haase BE, Managing diversity in health services organizations, *Hosp Health Serv Adm*, 1994;39(4):415-434.
35. Wilson-Stronks A, Galvez E, *Hospitals, Language and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals*, Oakbrook Terrace, IL: The Joint Commission; 2007.
36. Dreachslin J, Hobby F, Racial and ethnic disparities: Why diversity leadership matters, *J Healthc Manag*, 2008;53(1):8-13.
37. Hrebiniak LG, Joyce W, *Implementing Strategy*, New York: Macmillan Publishing Company; 1984.
38. Walsh DC, Rudd RE, Moeykens BA, et al., Social marketing for public health, *Health Aff (Millwood)*, 1993;12(2):104-119.
39. Kotler P, Roberto EL, *Social Marketing: Strategies for Changing Behavior*, New York: The Free Press; 1989.
40. Clark T, Sleath B, Rubin RH, Influence of ethnicity and language concordance on physician-patient agreement about recommended changes in patient health behavior, *Patient Educ Couns*, 2004;53(1):87-93.
41. Grantmakers in Health, *In the Right Words: Addressing Language and Culture in Providing Health Care*, San Francisco, CA: Grantmakers in Health; 2003.
42. Seijo R, Gomez H, Freidenberg J, Language as a communication barrier in medical care for Hispanic patients, *Hispanic J Behav Sci*, 1991;13(4):363-376.
43. Perez-Stable EJ, Napoles-Springer A, Miramontes JM, The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes, *Med Care*, 1997;35(12):1212-1219.
44. Fernandez A, Schillinger D, Grumbach K, et al., Physician language ability and cultural competence. An exploratory study of communication with Spanish-speaking patients, *J Gen Intern Med*, 2004;19(2):167-174.
45. Grantmakers in Health, *In the Right Words: Addressing Language and Culture in Providing Health Care*. San Francisco, CA: Grantmakers in Health; 2003.
46. Jacobs EA, Lauderdale DS, Meltzer D, et al., Impact of interpreter services on delivery of health care to limited English-proficient patients, *J Gen Intern Med*, 2001;16(7):468-474.
47. Tocher TM, Larson EB, Do physicians spend more time with non-English-speaking patients? *J Gen Intern Med*, 1999;14(5):303-309.
48. Enguidanos ER, Rosen P, Language as a factor affecting follow-up compliance from the emergency department, *Emerg Med*, 1997;15(1):9-12.
49. Weech-Maldonado R, Weidmer BO, Morales LS, et al., Cross-Cultural Adaptation of Survey Instruments: The CAHPS Experience. In: Cynamon M and Kulka R, eds., *Seventh Conference on Health Survey Research Methods*, pp. 75-82. Hyattsville, MD: Department of Health and Human Services. Available at [www.cdc.gov/nchs/data/conf/conf07.pdf](http://www.cdc.gov/nchs/data/conf/conf07.pdf). Last accessed October 2008.
50. Weidmer B, Hurtado M, Weech-Maldonado R, et al., *Guidelines for Translating CAHPS Surveys*, Rockville, MD: Agency for Healthcare Research and Quality; 2006.
51. Marin G, Marin BV, *Research with Hispanic Populations*, Newbury Park, CA: Sage Publications; 1991.
52. Department of Health and Human Services, *Healthy People 2010*. Available at [www.healthypeople.gov](http://www.healthypeople.gov). Last accessed October 2008.



53. Center for Healthcare Strategies, What is Health Literacy? Fact Sheet 1 to 9. Available at [www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=291711](http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711). Last accessed December 2005.
54. Ad Hoc Committee on Health Literacy for the Council of Scientific Affairs, Health literacy: Report of the council on scientific affairs, *JAMA*, 1999;281(6):552-557.
55. Williams MV, Davis T, Parker RM, et al., The role of health literacy in patient-physician communication, *Fam Med*, 2002;34(5):383-389.
56. Center for Healthcare Strategies, *Strategies to Assist Low-Literate Health Care Consumers*. Available at [www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=291711](http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711). Last accessed December 2005.
57. Lavizzo-Mourey R, Cultural competence: Essential measurements of quality for managed care organizations, *Ann Intern Med*, 1996;124(10):919-921.
58. Campinha-Bacote J, The process of cultural competence in the delivery of healthcare services: A model of care, *J Transcult Nurs*, 2002;13(3):181-184.
59. Kim-Godwin YS, Clarke PN, Barton L, A model for the delivery of culturally competent community care, *J Adv Nurs*, 2001;35(6):918-925.
60. DeRosa N, Kochurka K, Implement culturally competent care in your workplace, *Nurs Manage*, 2006;37(10):18-26.
61. Galanti GA, *Caring for Patients from Different Cultures*, Philadelphia, PA: University of Pennsylvania Press; 2004.
62. Hobgood C, Sawning S, Bowen J, et al., Teaching culturally appropriate care: A review of educational models and methods, *Acad Emerg Med*, 2006;13(12):1288-1295.
63. Weech-Maldonado R, Merrill SB, Building partnerships with the community: Lessons from the Camden Health Improvement Learning Collaborative, *J Healthc Manag*, 2000;45(3):189-205.
64. Viswanathan M, Ammerman A, Eng E, et al., *Community-Based Participatory Research: Assessing the Evidence*, Rockville, MD: Agency for Healthcare Research and Quality; 2004.
65. Cook WK, Integrating research and action: A systematic review of community-based participatory research to address health disparities in environmental and occupational health in the USA, *J Epidemiol Community Health*, 2008;62(8):668-676.
66. Weech-Maldonado R, Morales LS, Elliot MN, et al., Race/ethnicity, language and patient's assessments of care in Medicaid managed care, *Health Serv Res*, 2003;38(3):789-808.
67. Weech-Maldonado R, Elliot MN, Morales LS, et al., Health plan effects on patient assessments of Medicaid managed care among racial/ethnic minorities, *J Gen Intern Med*, 2004;19(2):136-145.
68. Weiner BJ, Alexander JA, Shortell SM, et al., Quality improvement implementation and hospital performance on quality indicators, *Health Serv Res*, 2006;42(2):307-334.
69. Larson L, Is your hospital culturally competent? (And what exactly does that mean exactly?), *Trustee*, 2005;58(2):2-3.
70. Moxley A, Mahendra N, Vega-Barachowitz C, Cultural competence in health care, *The ASHA Leader*, 2004:20-22. Available at [www.asha.org/about/publications/leaderonline/archives/2004/040413/f040413b1.htm](http://www.asha.org/about/publications/leaderonline/archives/2004/040413/f040413b1.htm). Last accessed October 2008.
71. Zambrana RE, Molnar C, Munoz HB, et al., Cultural competency as it intersects with racial/ethnic, linguistic, and class disparities in managed healthcare organizations, *Am J Manag Care*, 2004(Special Issue):SPO37-APO44.
72. Ministry for Children and Families, *Cultural Competency Assessment Tool*, Vancouver, Canada: Vancouver Ethnocultural Advisory Committee of Ministry for Children and Families; 2004.
73. Schim SM, Doorenbos A, Benkert R, et al., Culturally congruent care: Putting the puzzle together, *J Transcult Nurs*, 2007;18(2):103-110.
74. Williams RA, Cultural diversity, health care disparities, and cultural competency in American medicine, *J Am Acad Orthop*, 2007;15(1):S52-S58.



# A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

## Appendix B Glossary

**Community-based participatory research (CBPR)**—A collaborative approach to research that combines methods of inquiry with community capacity-building strategies to bridge the gap between knowledge produced through research and what is practiced in communities to improve health. Interest is growing rapidly in having academic institutions, health agencies, and communities form research partnerships; however, few agreed-upon guidelines describe how to develop or evaluate CBPR proposals or what resources are required to promote successful collaborative research efforts.

**Health professional**—Physicians, administrators, nurses, physical and occupational therapists, linguistic services providers, psychologist social workers, and others who provide care to a patient.

**High-quality healthcare**—Healthcare that is delivered in a safe, effective, patient-centered, timely, efficient, and equitable manner and that is state of the art and evidence based.


**Leadership**—In reference to Domain 1, it refers to leadership by the board of directors, trustees, and C-suite level and senior managers.

**Patient**—The individual recipient of care—that is, the patient, client, legal surrogate, or person.

**Primary written and spoken language**—The self-selected language the patient wishes to use to communicate with his or her healthcare provider.

**Threshold language**—Title 9 of the California Code of Regulations, Section 1810.410, addresses the Cultural and Linguistic Requirements of the public mental health systems in California. Section 1810.410(f) defines threshold language as a primary language spoken by 3,000 people, or 5 percent of the beneficiary population, whichever is lower in an identified geographic area. However, state requirements may vary, so state requirements should be followed.





A Comprehensive Framework and Preferred Practices  
for Measuring and Reporting Cultural Competency:  
A Consensus Report

## **Appendix C**

### **Implementation Examples Cross-Walked to Practices**

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Leadership—Organizational Culture</b>	2	Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.	<ul style="list-style-type: none"> <li>■ At WakeMed Health and Hospitals, in Raleigh, North Carolina, 70 percent of annual employee evaluation components focus on the demonstration of technical skills, and 30 percent focus on meeting organizational standards, including the commitment to understanding patients’ cultures and improving communication skills.</li> <li>■ Several hospitals in Illinois, North Carolina, New York, and Washington have written policies that strongly discourage or prohibit a patient’s family members or friends from being used as medical interpreters (Harborview Medical Center, Sherman Hospital, Woodhull Medical and Mental Health Center, and WakeMed Health and Hospitals).</li> <li>■ Three Iowa Health System sites have policies mandating that new patient education materials must be approved by patient education committees (Finley Hospital, Iowa Home Health Care, and Trinity Regional Medical Center Fort Dodge).</li> <li>■ The University of Virginia Health System has a “policy on policies” that provides guidance for clearly writing, classifying, and disseminating new policies.</li> </ul>
<b>Leadership—Commitment to Serving a Diverse Population</b>	3	Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.	<ul style="list-style-type: none"> <li>■ Cambridge Health Alliance in Boston is explicit about services offered to address cultural competency by meeting the needs of patients in its code of ethics. See <a href="http://www.cha.harvard.edu/aboutus/ethical_guidelines.shtml">www.cha.harvard.edu/aboutus/ethical_guidelines.shtml</a>.</li> </ul>
<b>Leadership—Policies</b>	6	Commit to cultural competency through systemwide approaches that are articulated through written policies, practices, procedures, and programs.	<ul style="list-style-type: none"> <li>■ The Los Angeles County Department of Health Services has integrated cultural and linguistic policies into a comprehensive plan that includes needs assessment, training, monitoring, and language service provision.<sup>1</sup></li> </ul>

more

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Leadership— Training and Development</b>	7	Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.	<ul style="list-style-type: none"> <li>■ The Disparities Solutions Center of Massachusetts General Hospital has developed and implements the Disparities Leadership Program, a year-long leadership program designed to tackle racial and ethnic disparities in healthcare. Components of this program include providing specific skills and knowledge for leaders in healthcare.<sup>2</sup></li> <li>■ The Migrant-Friendly Hospitals, a European project sponsored by the European Commission and Directorate General for Health and Consumers, has developed cultural competency training for hospital staff and leaders that focuses on cultural awareness, recognizing one’s own prejudices, and developing the relevant skills needed to provide care for diverse populations.<sup>3</sup></li> </ul>
<b>Integration into Management Systems and Operations—Service Planning</b>	9	Implement language access planning in any area where care is delivered.	<ul style="list-style-type: none"> <li>■ Kids Connections in Louisville, Colorado, employs eight service coordinators, three of whom are bilingual. All eligible families are assigned a service coordinator. The organization matches limited English proficiency (LEP) families with bilingual coordinators. The program provides services through contracts with early intervention therapists and collaborates with health departments, hospitals, doctors, child care providers, school districts, and other community services. The service coordinators work in partnership with other providers to ensure that children and families receive appropriate services.</li> <li>■ As suggested by the Department of Health and Human Services (DHHS) Office for Civil Rights, the Asian Pacific Health Care Venture (APHCV) has developed a written language access plan that outlines the practices APHCV employees must follow to comply with Title VI of the Civil Rights Act and Office for Civil Rights guidance. Four key areas are discussed: assessment of needs, development of policies and procedures, training of staff, and vigilant monitoring. Partial funding for the manual was provided by DHHS’ Bureau of Primary Health Care. It has been distributed to all APHCV employees and is periodically reviewed and revised.</li> <li>■ Model policies and procedures were developed to address issues of language access related to immigrants and visitors to the United States who are protected under civil rights law from discrimination based on national origin; they do not address access issues related to disability. Although based primarily on California public hospitals, they are adaptable to the entire U.S. hospital industry (state or local laws would need to be referenced, however).<sup>4</sup></li> </ul>

*more*

Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Integration into Management Systems and Operations—Service Planning</b> <i>(continued)</i>			<ul style="list-style-type: none"> <li>■ An Internet-based database designed to assist physicians and others in providing improved language access and culturally competent healthcare has been developed by the Medical Leadership Council on Cultural Proficiency, located in California. Free to the public, the database includes contact information for interpreters, nonprofit organizations, hospitals, public health departments, and others that provide health information and services in languages other than English. Users can search for listings by county, by language, or by type of service. The database helps users quickly find interpreters, materials about how to provide culturally competent care, information in several languages about specific diseases and healthy practices, and county-specific contacts for identifying additional sources of assistance.<sup>5</sup></li> </ul>
<b>Integration into Management Systems and Operations—Reward Systems</b>	10	Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.	<ul style="list-style-type: none"> <li>■ The U.S. Congress legislated the Baldrige Award in 1987, and the first awards were presented in 1988. Each year, applicants prepare detailed assessments of their management systems; their applications respond to the Criteria for Performance Excellence, which are built upon a set of 11 interrelated core values and concepts. The seven criteria categories provide a systems perspective of the elements essential to achieving performance excellence (see <a href="http://www.quality.nist.gov">www.quality.nist.gov</a>).</li> <li>■ The National Committee for Quality Assurance (NCQA) established the Recognizing Innovation in Multicultural Health Care Award program to recognize innovative programs provided by specific health plans for identifying and reducing care disparities related to culturally and linguistically appropriate services (CLAS); the Innovative Practices report highlights the award-winning plans. Health plans must fill out an application and describe their programs in detail, including any measurable outcomes. NCQA staff members convene a panel of experts to evaluate the initiatives using standardized forms based on six criteria: rationale or conceptual framework; innovative/creative approach to reducing healthcare disparities; evidence of impact on services or outcomes; sustainability; transferability; and organizational integration and leadership.</li> </ul>

more



## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Integration into Management Systems and Operations—Marketing and Public Relations</b>	11	Market culturally competent services to the community to ensure that communities that need services receive the information.	<ul style="list-style-type: none"> <li>■ Kaiser Permanente has launched an electronic media campaign to promote preventive healthcare and healthy living.<sup>6</sup> This campaign includes ads as well as a user-friendly interactive website that is a source of information and resources.</li> <li>■ Health Net of California has partnered with Mexican healthcare providers to form a cross-border healthcare plan, allowing Mexican immigrants and Californians to receive the same quality of care services.<sup>7</sup></li> </ul>
<b>Patient-Provider Communication—Language Access</b>	13	Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.	<ul style="list-style-type: none"> <li>■ North DeKalb in Chamblee, Georgia, a satellite clinic of Grady Hospital, employs one full-time interpreter, two bilingual physicians, and a bilingual support staff member. The full-time interpreter provides most of the interpretation services. In her absence, physicians occasionally use bilingual medical staff, mainly nurses, for interpretation.</li> <li>■ The cultural and linguistic services department of L.A. Care periodically surveys participating providers and monitors developments and innovations nationally and in the research literature. Using this information, as well as its own research studies and reports, L.A. Care is constantly developing language services and information for its participating providers.</li> <li>■ At Planned Parenthood of Pennsylvania in York, Pennsylvania, bilingual staff members generally answer the phone. If not, when a LEP patient calls, the individual answering the phone immediately asks for assistance from a bilingual staff member. LEP patients' language needs are noted when their appointments are scheduled to ensure that a bilingual staff member will be available to interpret.</li> <li>■ The Washoe County in Reno, Nevada, Family Planning Program employs only bilingual Spanish-speaking support staff for its telephone language line. Every day, four to six bilingual staff members are onsite. One of the nurse practitioners speaks limited Spanish but occasionally requires assistance communicating with patients. Most of this practitioner's schedule is dedicated to serving LEP patients.</li> <li>■ Chinatown Pediatric Service (CPS) in Philadelphia is a fully bilingual clinic with staff who speak English, Chinese, and Vietnamese. The clinic's physician, Dr. Philip Siu, also serves as the director of Thomas Jefferson University Hospital's Chinese Health Information Center. Approximately 95 percent of CPS's patients speak Chinese (60 percent speak Mandarin; 40 percent speak Cantonese). Many staff members are from Vietnam and speak Cantonese. Approximately 5 percent of patients are ethnic Japanese, Cambodian, and French and can communicate adequately in English.</li> </ul>

*more*

Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Patient-Provider Communication— Language Access</b> <i>(continued)</i>			<ul style="list-style-type: none"> <li>■ Saint Joseph Health System Community Health Programs, Santa Rosa, California, uses mobile clinics to offer health and dental services. The Saint Joseph Mobile Health Clinic, in operation since 1990, offers health screenings and well-child exams, immunizations, treatment of minor medical problems, health and nutritional education, other information, and referrals. The clinic serves low-income children and adults who do not have regular primary care physicians and those who have difficulty obtaining affordable healthcare. The clinic is in the field four days each week and rotates among six high-need sites throughout Sonoma County. Most staff members are bilingual. Approximately 97 percent of the patients are Spanish speaking.</li> </ul>
<b>Patient-Provider Communication— Interpreter Services</b>	14	Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.	<ul style="list-style-type: none"> <li>■ Los Angeles County Department of Health Services currently implements this practice. In its implementation, it is further specified that signage be in at least the threshold languages for MediCal Managed Care, and it will say: “You have the right to an interpreter at no cost to you. Ask at the front desk.” In addition, a “Point to Your Language” card in at least the MediCal threshold languages will be maintained at the points of contact for the patient.<sup>8</sup></li> <li>■ Speaking Together, a National Language Services Network funded by the Robert Wood Johnson Foundation, pilots new performance measures with hospitals and tests techniques for reducing healthcare disparities. Hospitals should adopt these same practices by working toward core measures for language services to track their performance.<sup>9</sup></li> </ul>

more

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Patient-Provider Communication— Health Literacy Strategies</b>	18	Use “teach back” as a patient engagement tool to enhance communication between the healthcare provider and the patient during clinical encounters.	<ul style="list-style-type: none"> <li>■ A study conducted by the Association of Clinicians for the Underserved in 2005 found that multiple sites in Arizona, Michigan, Texas, and Washington use informal “teach back” methods to increase and improve communication between patients and providers. The sites include Desert Senita Community Health Center in Ajo, Arizona, Center for Family Health in Jackson, Michigan, Ferguson Adult Health Center of the Cherry Street Health Services in Grand Rapids, Michigan, Community Health Partnership, Inc., in Eau Claire, Wisconsin, and Parkland Health and Hospital System, East Dallas Health Center.</li> <li>■ In 1997, Puget Sound Education Service District Head Start launched a Peer Health Education Program in the Seattle area. The peer educators are Head Start parents who are trained to teach other parents how to navigate the healthcare system and advocate for their families’ health.<sup>10</sup></li> </ul>
<b>Patient-Provider Communication— Health Literacy Strategies</b>	19	Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.	<ul style="list-style-type: none"> <li>■ The National Quality Forum evaluated three hospitals that met the criteria of having implemented, at a minimum, the teach back component of (then) Safe Practice 2 as a routine practice for informed consent or for related components of the surgical preparation process: 1) Sherman Hospital, located in Elgin, Illinois; 2) Shriners Hospitals for Children-Los Angeles; and 3) the University of Virginia Health System, in Charlottesville, Virginia.<sup>11</sup></li> </ul>
<b>Patient-Provider Communication— Cultural Awareness</b>	20	Regularly assess attitudes, practices, policies, and structures of all staff as a necessary, effective, and systematic way to plan for and incorporate cultural competency within an organization.	<ul style="list-style-type: none"> <li>■ The Joint Commission provides a self-assessment that hospitals can use.<sup>12</sup></li> </ul>
<b>Care Delivery and Supporting Mechanisms—Clinical Encounter</b>	22	If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.	<ul style="list-style-type: none"> <li>■ UnitedHealthcare developed the Asian In-Language provider directory to promote patient-provider racial, ethnic, and language concordance. Through better patient-provider matching, this initiative facilitates effective communication of medical needs and enhanced medical outcomes by promoting linguistic and cultural sensitivity. Anyone who has access to a computer can access this practice, and those who speak Chinese, Korean, or Vietnamese will benefit from the ability to access the necessary data in their own languages at any time. See <a href="http://www.uhcasian.com/English/guests/G_M_F.html">www.uhcasian.com/English/guests/G_M_F.html</a>.</li> </ul>

more

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Care Delivery and Supporting Mechanisms—Physical Environment</b>	25	Adapt the physical environment where the healthcare is being delivered to represent the culture of the populations who access their healthcare in that environment.	<ul style="list-style-type: none"> <li>■ The Lutheran Family Health Centers of Lutheran HealthCare provide a high-quality and convenient healthcare safety net for neighborhoods throughout southwest Brooklyn. The clinics, such as the Brooklyn Chinese Center and the Caribbean-American Family Health Center, provide services matched to the needs of the communities they serve.<sup>13</sup></li> <li>■ The Alaska Native Medical Center is a tribally owned and operated healthcare facility that provides a full range of services to eligible Alaska Natives and American Indians who live in Alaska and has tailored its clinics to reflect the populations they serve.<sup>14</sup></li> </ul>
<b>Care Delivery and Supporting Mechanisms—Coordination of Care</b>	26	Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.	<ul style="list-style-type: none"> <li>■ Hennepin County Medical System provides community liaisons to help patients who are receiving services.<sup>15</sup></li> </ul>
<b>Care Delivery and Supporting Mechanisms—Health Information Technology</b>	27	Explore, evaluate, and consider the use of multimedia approaches and health information technology to enable the provision of healthcare services that are patient and family centered and culturally tailored to the patient.	<ul style="list-style-type: none"> <li>■ New York City's Bellevue Hospital uses remote simultaneous medical interpreting (RSMI), a new translation method that is improving patients' experiences and outcomes. RSMI allows two parties to speak into enhanced telephones while an off-site interpreter translates.</li> <li>■ Computer kiosks at Cook County Hospital clinics help patients with diabetes and low literacy skills understand their susceptibility to complications.</li> <li>■ California's Department of Managed Health Care provides approximately 5,000 farm workers and their families with access to information about their medical conditions, medications, procedures, and lab results. The information provided through this password-protected portal can be updated by both patients and healthcare providers.</li> </ul>

more

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Workforce Diversity and Training— Recruitment and Retention</b>	28	Recruit and hire ethnically diverse providers and staff at all levels, including management levels.	<ul style="list-style-type: none"> <li>■ Mount Olive Pediatrics is a satellite office of Goldsboro Pediatrics in Mount Olive, North Carolina. It employs bilingual midlevel practitioners who conduct examinations and clinical visits in Spanish and also assist physicians and other office personnel during encounters with Spanish-speaking patients. The office employs a bilingual certified pediatric nurse practitioner three days per week who coordinates many of the language and cultural access activities. She also translates educational materials and provides office staff with on-the-job training regarding Spanish terms, cultural beliefs, and alternative medicine. A bilingual certified nurse’s assistant also sees Spanish-speaking patients.</li> <li>■ Goldsboro Pediatrics in North Carolina employs a part-time bilingual pediatrician at its other offices throughout North Carolina. In addition, it employs a certified nurse assistant and two nurse practitioners who have attended community college courses designed to improve conversational Spanish skills.</li> </ul>
<b>Workforce Diversity and Training— Recruitment and Retention</b>	29	Actively promote the retention of a culturally diverse workforce through organizational policies and programs.	<ul style="list-style-type: none"> <li>■ Barnes-Jewish Hospital in St. Louis, Missouri, has created a Center for Diversity and Cultural Competence to promote diversity and cultural competence initiatives and programs throughout the hospital and community and to oversee programs for its LEP patient population and through its Refugee and Interpreter Services program.<sup>16</sup></li> </ul>
<b>Community Engagement— Community Outreach</b>	31	Engage communities to ensure that healthcare providers (individual and organizational) are aware of current and changing patient populations and cultural and communication needs and provide opportunities to share resources and information.	<ul style="list-style-type: none"> <li>■ University of Virginia Health Systems works closely with the local International Rescue Committee (IRC) and health department to coordinate the healthcare of refugees in Charlottesville. Without the IRC as a partner, the hospital would have to expend greater resources in caring for diverse refugee populations by providing social workers, case managers, and interpreters for rare languages.</li> <li>■ The CEO at Sherman Hospital in Elgin, Illinois, appoints community members to serve on the hospital’s governing board. As members retire from the board, the CEO strives to find new members who represent the community’s demographic profile.</li> <li>■ As part of the New York public hospital system, Woodhull Medical and Mental Health Center is required to have a community advisory board. The board meets monthly and serves as an advocate for the community.</li> <li>■ Harborview Medical Center in Seattle, Washington, has a community advisory board specifically for its Community House Calls program. The hospital uses this board to establish relationships with local community groups, learn from community members, understand community-specific issues, and provide a forum through which the hospital can receive feedback from its communities.</li> </ul>

*more*

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Community Engagement— Community Outreach</b>	32	Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.	<ul style="list-style-type: none"> <li data-bbox="1050 337 1967 581">■ The three-year Diabetes Education and Treatment Initiative was launched in April 2005, in partnership with La Clinica del Pueblo, one of the only free nonprofit health clinics serving uninsured Latinos in Washington, DC. The three components of the program are implementation of the Chronic Care Model, an evidenced-based approach that allows for the electronic tracking, monitoring, and evaluation of client services; the provision of intensive education by culturally competent health educators; and the use of a home visit diabetes counseling program that provides peer health education or “promotores” to enhance self-management strategies.</li> <li data-bbox="1050 589 1967 792">■ The Health Awareness for Immigrants Program in Sacramento, California, is a three-year partnership with the Boat People SOS, a Vietnamese organization that promotes education for early detection and treatment of cervical cancer for Vietnamese women. Using a multimethod intervention, a mass media campaign targets local and national audiences, while bilingual health advocates and trained volunteers provide ongoing case management and home visiting services to link women with service providers.</li> <li data-bbox="1050 800 1967 979">■ In a three-year partnership with the University of Maryland School of Medicine, CareFirst is promoting cardiovascular health among African Americans through its Hair, Heart and Health (HHH) program. Barbers, hair stylists and outreach workers are trained and certified as Blood Pressure Measurement Specialists to provide health education and blood pressure screenings in barbershops and hair salons in Baltimore City, Maryland.</li> <li data-bbox="1050 987 1967 1117">■ As part of a comprehensive strategy to address health disparities, CareFirst staff nurses and physicians received cross-cultural training over a two-month period through a web-based program called Quality Interactions developed by the Manhattan Cross Cultural Group in Marshfield Hills, Massachusetts.</li> </ul>

*more*

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Community Engagement— Community Investments</b>	34	Healthcare professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.	<ul style="list-style-type: none"> <li>■ In 2007, Massachusetts General Hospital (MGH) sought approval from the Massachusetts Department of Public Health (DPH) to construct a new building on the downtown campus. Through a “determination of need” process, DPH must set aside a portion of the project cost to improve the health of the community. As a result, MGH will make an \$18.6 million commitment to improving the health of communities over the next five to seven years. This package will focus primarily on MGH’s partner communities of Chelsea, Revere, and Charlestown.</li> <li>■ Montefiore Medical Center partners with national and community-based groups on health outreach studies and programs that target specific needs—especially those of children, women, and seniors. It has a development arm, Montefiore’s Mosholu Preservation Corporation, formed in 1981 to promote the safety and vitality of the neighborhoods around its facilities, particularly in the northwest Bronx, New York.</li> <li>■ Washington Hospital Center in Washington, DC, invests in the training, promotion, and evaluation of its House Call Program aimed at delivering regular care in the patient’s home, improving the quality of life for elderly residents.</li> </ul>
<b>Community Engagement— Community-Based Participatory Research</b>	35	Use the methodology of community-based participatory research when conducting research in the community as a collaborative approach to research that equitably involves all stakeholders in the research process and fosters the unique strengths that the community brings to the process.	<ul style="list-style-type: none"> <li>■ The Centers for Disease Control and Prevention funds three Urban Research Centers to conduct community-based participatory research.<sup>17,18</sup></li> <li>■ Supported by a grant from the W.K. Kellogg Foundation at the University of Michigan School of Public Health, the Community Health Scholars Program (CHSP) is a postdoctoral fellowship program designed to meet the growing needs of schools of public health and other health professions for faculty who are culturally competent. The CHSP postdoctoral program enables scholars to develop and enhance skills in working with communities and engaging in community-based participatory research.<sup>19</sup></li> </ul>

more

## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Data Collection, Public Accountability, and Quality Improvement— Collection of Patient Cultural Competency-Related Information</b>	36	Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit <sup>20</sup> to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner.	<ul style="list-style-type: none"> <li>■ Expecting Success and Speaking Together, both Robert Wood Johnson-funded programs, collect race/ethnicity and primary written and spoken language data.</li> </ul>
<b>Data Collection, Public Accountability, and Quality Improvement— Collection of Community Cultural Competency-Related Information</b>	38	Utilize indirect data collection methodologies (e.g., geocoding, surname analysis) to characterize the race, ethnicity, and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.	<ul style="list-style-type: none"> <li>■ The Agency for Healthcare Research and Quality has produced the National Healthcare Quality Report and the National Healthcare Disparities Report, which measure trends in effectiveness of care, patient safety, timeliness of care, patient-centeredness, and efficiency of care. They present, in chart form, the latest available findings on the quality of and access to healthcare.<sup>21</sup></li> <li>■ Expecting Success and Speaking Together, both Robert Wood Johnson funded-programs, collect race/ethnicity and primary written and spoken language data.</li> </ul>
<b>Data Collection, Public Accountability, and Quality Improvement— Assessment of Patient Experiences with Care</b>	43	Assess and improve patient- and family-centered communication on an ongoing basis.	<ul style="list-style-type: none"> <li>■ As part of a planning grant, WakeMed Health and Hospitals in Raleigh, North Carolina, conducted a series of “secret shopper” visits to determine patient experiences with different areas of the hospitals. The hospitals found that, in many cases, staff members were not able to communicate with patients who did not speak English.</li> <li>■ Woodhull Medical and Mental Health Center sent a team to visit the Cambridge Alliance to observe and learn from its cultural diversity and language programs. WakeMed Health and Hospitals visited other North Carolina institutions, including a regional health department, to see how sites serving similar populations provide language assistance services.</li> </ul>

more



## Appendix C—Implementation Examples Cross-Walked to Practices

DOMAIN—SUBDOMAIN	PRACTICE NUMBER	PRACTICE STATEMENT	IMPLEMENTATION EXAMPLES
<b>Data Collection, Public Accountability, and Quality Improvement— Documentation of Cross-Cultural Complaints and Resolutions</b>	45	Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.	<ul style="list-style-type: none"> <li>The Los Angeles County Department of Health Services maintains a log of cultural and language complaints and complaint resolutions. This log is included in the facility's required complaint report issued quarterly.<sup>22</sup></li> </ul>

### NOTES

- Los Angeles County Department of Health Services, *Cultural and Linguistic Competency Standards*; 2003, pp. 15-22.
- The Disparities Solution Center, 17 Healthcare organizations selected for national leadership program to eliminate racial and ethnic disparities in healthcare; 2008. Press Release.
- Schulze B, Krajcik K, Trummer U, *Migrant-Friendly Hospitals. Subproject C: Staff Training Toward Cultural Competence: Fact Sheet*, Institute for the Sociology of Health and Medicine; 2004, pp.1-8. Available at [www.mfh-eu.net/public/files/experiences\\_results\\_tools/spc\\_training/SPC\\_factsheet.pdf](http://www.mfh-eu.net/public/files/experiences_results_tools/spc_training/SPC_factsheet.pdf). Last accessed February 2009.
- California Health Care Safety Net Institute, *Straight Talk: Model Hospital Policies and Procedures on Language Access*. California Health Care Safety Net Institute; 2005. Available at [www.safetynetinstitute.org/publications/documents/StraightTalkFinal.pdf](http://www.safetynetinstitute.org/publications/documents/StraightTalkFinal.pdf). Last accessed September 2008.
- Medical Leadership Council of Cultural Proficiency, *Language Access Database*. Medical Leadership Council; 2009. Available at [www.medicalleadership.org/resource\\_database.shtml](http://www.medicalleadership.org/resource_database.shtml)
- Rauber C, Kaiser makes \$40M pitch: health plan gets a legume up on the competition, *San Francisco Business Times*; July 30 2004. Available at [www.bizjournals.com/sanfrancisco/stories/2004/08/02/story2.html](http://www.bizjournals.com/sanfrancisco/stories/2004/08/02/story2.html). Last accessed March 2009.
- National Committee for Quality Assurance, *Innovative Practices in Multicultural Health Care*; 2006, pp. 14-15.
- Los Angeles County Department of Health Services, *Cultural and Linguistic Competency Standards*; 2003, pp. 15-22.
- The George Washington University Medical Center, Robert Wood Johnson Foundation, *In Any Language: Improving the Quality and Availability of Language Services in Hospitals*; 2008, pp. 3-15.
- See <http://eclkc.ohs.acf.hhs.gov/hslc>.
- National Quality Forum (NQF), *Implementing a National Voluntary Consensus Standard for Informed Consent: A User's Guide for Healthcare Professionals*, Washington, DC: NQF; 2005.
- Wilson-Stronks A, Lee KK, Cordero CL, et al., *One Size Does Not Fit All: Meeting The Health Care Needs of Diverse Populations*, Oakbrook Terrace, IL: The Joint Commission; 2008.
- See [www.lutheranmedicalcenter.com/OurFacilities/LutheranFamilyHealthCenters/](http://www.lutheranmedicalcenter.com/OurFacilities/LutheranFamilyHealthCenters/). Last accessed March 2009.
- See <http://anmc.org/>. Last accessed March 2009.
- See [www.co.hennepin.mn.us/portal/site/HCIInternet/menuitem.3f94db53874f9b6f68ce1e10b1466498/?vgnextoid=5befb6764b9fc010VgnVCM1000000f094689RCRD&vgnextfmt=default](http://www.co.hennepin.mn.us/portal/site/HCIInternet/menuitem.3f94db53874f9b6f68ce1e10b1466498/?vgnextoid=5befb6764b9fc010VgnVCM1000000f094689RCRD&vgnextfmt=default). Last accessed March 2009.
- See [www.barnesjewish.org/groups/default.asp?NavID=3748](http://www.barnesjewish.org/groups/default.asp?NavID=3748). Last accessed March 2009.
- Higgins DL, Metzler M, Implementing community-based participatory research centers in diverse urban settings, *J Urban Health*, 2001;78(3):488-494. Available at [http://depts.washington.edu/ccph/pdf\\_files/Higgins.pdf](http://depts.washington.edu/ccph/pdf_files/Higgins.pdf). Last accessed March 2009.
- Eisinger A, Senturia K, Doing community-driven research: a description of Seattle Partners for Healthy Communities, *J Urban Health*, 2001;78(3):519-534. Available at [http://depts.washington.edu/ccph/pdf\\_files/Eisinger.pdf](http://depts.washington.edu/ccph/pdf_files/Eisinger.pdf). Last accessed March 2009.
- See [www.montefiore.org/whoware/communityservices/](http://www.montefiore.org/whoware/communityservices/). Last accessed March 2009.
- Hasnain-Wynia R, Pierce D, Haque A, et al., *Health Research and Educational Trust Disparities Toolkit*; 2007. Available at [www.hretdisparities.org](http://www.hretdisparities.org). Last accessed September 2008.
- See [www.ahrq.gov/qual/qrd07.htm](http://www.ahrq.gov/qual/qrd07.htm). Last accessed March 2009.
- Los Angeles County Department of Health Services, *Cultural and Linguistic Competency Standards*; 2003, pp. 15-22.



THE NATIONAL QUALITY FORUM (NQF) is a private, nonprofit, open membership, public benefit corporation whose mission is to improve the American healthcare system so that it can be counted on to provide safe, timely, compassionate, and accountable care using the best current knowledge. Established in 1999, NQF is a unique public-private partnership having broad participation from all parts of the healthcare industry. As a voluntary consensus standard-setting organization, NQF seeks to develop a common vision for healthcare quality improvement, create a foundation for standardized healthcare performance data collection and reporting, and identify a national strategy for healthcare quality improvement. NQF provides an equitable mechanism for addressing the disparate priorities of healthcare's many stakeholders.

NATIONAL QUALITY FORUM  
601 13th Street NW  
Suite 500 North  
Washington, DC 20005  
202-783-1300  
[www.qualityforum.org](http://www.qualityforum.org)

