TAKING CULTURAL COMPETENCY FROM THEORY TO ACTION

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October 2006

ABSTRACT: This paper provides principles and recommendations for implementing cultural competency in the field. The following six principles are key to a successful cultural competency effort: 1) community representation and feedback at all stages of implementation; 2) cultural competency integrated into all systems of the health care organization, particularly quality improvement efforts; 3) ensuring that changes made are manageable, measurable, and sustainable; 4) making the business case for implementation of cultural competency polices; 5) commitment from leadership; and 6) staff training on an ongoing basis. Based on interviews with leaders in the field of cultural competency, the authors discuss best practices and important lessons in the implementation of cultural competency initiatives.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This report and other Fund publications are available online at www.cmwf.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 964.

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ACKNOWLEDGMENTS

The authors would like to thank the following for their contributions to CPEHN's cultural competency conference and for agreeing to be interviewed: Nancy Steiger, R.N., M.S., chief executive officer at the San Mateo Medical Center; Dr. Gamini Gunawardane, Ph.D., J.D., director of legal and regulatory affairs and culturally and linguistically appropriate services at Care1st Health Plan; Nicole Reavis, M.Ed., project director, National Initiative for Children's Healthcare Quality; Beatriz Solís, M.P.H., former director of cultural and linguistic services, L.A. Care Health Plan; Boris Kalanj, M.S.W., L.I.S.W., director of cross-cultural care and interpreter services, Children's Hospitals and Clinics in Minneapolis and St. Paul, Minn.; Stephen Bohlen, Esq., Business Affairs Dept., Woodhull Medical and Mental Health Center; Sunita Mutha, M.D., program director, LEADing Organizational Change: Advancing Quality through Culturally Responsive Care. We also would like to thank The Commonwealth Fund for its support of this paper, and in particular the Fund's Anne Beal, M.D., for her assistance with framing and organizing the ideas presented here. In addition, we gratefully acknowledge Laurin Mayeno of Organizational Change and Community Health for her guidance and feedback on earlier drafts.

Editorial support was provided by Deborah Lorber.

EXECUTIVE SUMMARY

In the past 10 years, there has been a profusion of research in the field of cultural and linguistic competency, particularly on the capability of language services to improve the quality of patient care. However, while much work has focused on defining cultural competency, there has been considerably less on taking cultural competency from theory to action. This paper provides principles and recommendations for implementing cultural competency in the field. The following six key principles—discussed at length in this report—are key to a successful cultural competency effort:

- Community representation and feedback is essential at all stages of implementation.
- Cultural competency must be integrated into all existing systems of a health care organization, particularly quality improvement efforts.
- Changes made should be manageable, measurable, and sustainable.
- Making the business case for undertaking cultural competency initiatives is critical for long-term sustainability.
- Commitment from leadership is a key factor to success.
- Ongoing staff training is crucial.

The authors developed these principles based on their close ties with communities of color, their experience advocating for cultural and linguistic requirements, and an analysis of existing best-practice standards. Through interviews with key leaders in the field of cultural competency, they developed case studies based on specific practices and lessons learned from implementation of cultural competency initiatives.

Highlights from these case studies include:

- A project conducted by the National Initiative for Children's Healthcare Quality sought to integrate quality improvement and cultural competency in clinics. Participating providers found that providing trained interpreters—even by telephone—resulted in better communication, more appropriate diagnosis, and a deeper understanding of patient needs. Staff exposure to different cultures increased comfort in dealing with diversity and the use of more effective treatment plans. In addition, capturing data about race and ethnicity enabled programs to examine and address gaps in practice.

- At L.A. Care Health Plan, a non-profit, community health maintenance organization in Los Angeles, data from an employee survey—which found employees with more direct member contact were less satisfied and more pessimistic—was used to identify the need for cultural competency training and obtain commitment and resources for their implementation and evaluation.
- With the advent of new, committed leadership, Children's Hospitals and Clinics of Minnesota created a department for interpreter services. In addition to providing translation services, the hospital began using interpreters as cultural mediators, a change that addresses cultural competency in addition to language access. The new processes are well-integrated into the system—and well received by patients and the community—and therefore protected against potential changes in leadership.
- At Woodhull Medical and Mental Health Center, in Brooklyn, N.Y., the leadership sought to make large-scale, sweeping changes. Cultural competency is incorporated into the organization's mission, framed as a patient safety and customer service issue. Woodhull asks all patients what their language preferences are and whether they require an interpreter. The facility uses staff interpreters, with a telephone language line vendor as backup. In addition, cultural competency training is incorporated into the corporate-wide, five-day orientation for new hires.
- LEADing Organizational Change: Advancing Quality through Culturally Responsive Care (LEAD)—a three-year initiative to enhance the quality of care among California's public hospitals—illustrates the range of experiences of provider organizations in improving cultural competency. As the authors found, hospitals and other providers must carefully manage the size of changes they seek to implement; measure the effect of those changes; and frame cultural competency as a quality-of-care issue.

The authors believe that only by addressing the aforementioned principles can health care organizations—as well as the health care system as a whole—become more culturally competent and ensure the delivery of quality health care to diverse communities. In transforming theory into practice, they recommend that organizations:

- Seek out leaders of community groups to solicit their concerns and recommendations.
- Make cultural competency a component of disease management, quality improvement, patient safety, customer service, and patient–provider interaction.

- Consider how they will evaluate and quantify the positive impact of their cultural competency efforts.
- Explore the business case for implementing cultural competency initiatives, considering the social benefits of providing culturally competent care, improved market share, and decreased liability.
- Recruit a racially and ethnically diverse workforce and leadership that are committed to equality in health care.
- Support staff trainings by dedicating time and resources to implementation and ensuring that regular scheduling is part of formal policy.

TAKING CULTURAL COMPETENCY
FROM THEORY TO ACTION

INTRODUCTION

In the past 10 years, there has been a profusion of research in the field of cultural and linguistic competency, particularly focused on the capability of language services to improve the quality of patient care. However, while much work has focused on defining cultural competency, there has been considerably less on taking cultural competency from theory to action. This report is intended to provide health care organizations with guidance in making their systems and services more culturally competent to improve patient care. It includes practical examples and specific recommendations for engaging providers, advocates, accreditors, regulators, and funders in taking action at multiple levels.

Methods

In preparing this report, the authors drew upon the following:

- California Pan-Ethnic Health Network's (CPEHN) 14 years of experience as a statewide network of health advocacy organizations in California's African American, Asian American, Latino, and Native American communities.
- Proceedings from CPEHN's conference, "Practical Approaches to Cultural Competency: Working for Equality in Health," held in Oakland, Calif., in September 2005. Panelists and speakers included national and state experts on cultural competency and representatives from a range of perspectives, including community organizations, accreditors, health plans, hospitals, consumers, and major health care philanthropies. The panels focused on increasing quality of care through cultural competency and integrating cultural competency into practice. (A conference summary is available at www.cpehn.org.)
- In-depth interviews with five leaders working to improve the cultural competency of health care delivery systems. The organizations, which were selected based on consultation with a variety of experts in the field, represent health plans, hospitals, and community health centers. The leaders were asked about specific practices and lessons learned to identify concrete examples of successful implementation of cultural competency.

ESSENTIAL PRINCIPLES OF CULTURAL COMPETENCY

For purposes of this analysis, cultural competency is defined as a system of health care services delivery in which care and services are provided in a way that respects the

patient and results in each patient receiving equal care regardless of cultural background, national origin, race or ethnicity, English-language fluency, literacy level, socioeconomic status, or other relevant factors. Cultural competency involves equality in health care access and outcomes. In keeping with this definition, the following principles were identified for taking cultural competency from theory to practice.

Principle 1: Community representation and feedback are essential at all levels of the organization. Community participation and feedback is the most essential component of cultural competency. Meaningful community participation not only provides a health care organization with an understanding of its patients' needs, it also helps to allocate resources effectively and establishes a system to hold the organization accountable for providing quality services.

The importance of community participation has been recognized in federal and state guidelines and requirements. Standard 12 of the U.S. Department of Health and Human Services' Office of Minority Health (OMH) Culturally and Linguistically Appropriate Services (CLAS) in Health Care states: **"**health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities." Meanwhile, in California, the state's Medicaid managed care program and State Children's Health Insurance Program (Medi-Cal Managed Care and Healthy Families) requires health plans to establish community advisory boards as a means of creating community linkages to ensure the appropriateness of their services.

While community involvement is essential to culturally competent care, it can also be difficult to achieve. In particular, the consumer's voice is often absent in the planning and implementation stages. Health care organizations must have meaningful processes for community representation and feedback, which might include focus groups, advisory committees, or board representation.

United Indian Health Services provides an example of how to successfully engage community members from the beginning of the process. When United created its community clinic, Health Village, in Arcata, Calif., the architects met with tribal elders and providers and asked, "What does the community need for wellness?" Responses were incorporated into the design for Health Village. Buildings are modeled after traditional Native American homes, with each department in a separate house. There is a gathering room where community members are welcomed into Health Village, and each door faces

a “wellness garden,” which is also a water source. The participatory process ensured the health center would be a welcoming environment for the community.

The Children’s Hospitals and Clinics of Minnesota hired community outreach workers to market and solicit feedback to improve services. As a result, the organization experienced an increase in the number patients with limited English proficiency (LEP), and an increase in patient satisfaction. By engaging the community, the Children’s Hospitals and Clinics of Minnesota were able to improve the appropriate utilization of services and patient care. As part of a National Initiative for Children’s Healthcare Quality (NICHQ) project, the clinics met with leaders in the community to learn about the demographic shifts in their population, which enabled them to make changes that were not only responsive to the needs of the community but were also supported by the community.

By getting community feedback, an organization can more accurately determine patient needs, taking into account preferences, concerns, and cultural attitudes. Services are delivered more efficiently and effectively, increasing consumer satisfaction and improving patient care. In addition, strong community relations help develop support for the organization and its services.

Principle 2: Cultural competency must be integrated into all existing systems of a health care organization, particularly quality improvement efforts. Dedicated staff and resources for cultural competency are crucial, but cultural competence must not be treated as a separate issue or a distinct function. Instead, cultural competence must be viewed as integral and incorporated into all aspect of the organization and its structures. For example, OMH’s CLAS Standard 9 states: “Health care organizations… are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessment, and outcomes-based evaluations.”

In addition, integrating cultural competency into existing systems helps protect against a tendency to eliminate cultural competency efforts when organizations face budget cuts. This approach also helps staff better understand the issues and goals, and minimizes resentment of having to take on another project. Integrating cultural competency into existing systems and services allows organizations to think about how these issues fit into their goals and strategies and ensure that is not just viewed as the “project-of-the-day.”

Of particular importance is incorporating cultural competence into quality improvement programs. In California, Medi-Cal Managed Care and Healthy Families' cultural and linguistic requirements specifically outline how a health plan can incorporate components of cultural competency into its quality improvement program by using indicators that enable them develop strategies to refine operations.

At CPEHN's 2005 cultural competency conference, Nancy Steiger, R.N., M.S., chief executive officer at the San Mateo (Calif.) Medical Center, described how her organization linked cultural competence to patient safety and service excellence in an effort to promote a culture of safety. Cultural competence has been built into staff orientation, ongoing training, job descriptions, policies, and procedures. Initially, cultural competence, language access, service excellence, and patient safety were all separate initiatives, but all are now connected. Steiger found that framing cultural competency as a patient safety and service excellence issue made it easier to understand, helped build organizational support for improvements, and ensured integration into existing systems.

Gamini Gunawardane, Ph.D., J.D., director of legal and regulatory affairs and CLAS at Care1st Health Plan, talked about his organization's efforts to integrate culture into health care management activities and test documents for cultural appropriateness. He recommends that organizations follow a "total quality management" approach to integrating cultural competency.

NICHQ integrated cultural competency strategies into an existing, widely accepted quality improvement framework. This made cultural competency more palatable and sustainable to participating clinics. Children's Hospitals and Clinics of Minnesota integrated cultural competency into patient safety efforts and measured the impact through the filing of patient safety reports. As a result, there was a measurable decrease in medical errors and accidents.

Principle 3: Changes made must be manageable, measurable, and sustainable. Several leaders interviewed for this study indicated that organizations are most successful when changes are incremental and manageable relative to the organization's capacity Changes should be implemented methodically, with careful evaluation of successes and challenges, and impact must be measured to create a clear case for continuing efforts even in the face of a change in leadership or funding levels.

Many health care organizations use the plan-do-study-act (PDSA) cycle, or rapid-change cycle, to advance cultural competency and measure its impact. PDSA allows

small, incremental changes to be made and then provides time to study the effects of the change before implementing the intervention on a larger scale. The Institute for Healthcare Improvement (http://www.ihi.org) has developed a PDSA worksheet.

As will be illustrated below, the LEADing Organizational Change: Advancing Quality through Culturally Responsive Care initiative (LEAD) implemented the PDSA cycle to make incremental changes, measure their impact, and refine them. Participants at LEAD found hospitals that adopted smaller, manageable projects were more successful than those that could not narrow their goals or evaluate their changes.

Nicole Reavis, M.Ed., project director at NICHQ, spoke at CPEHN's cultural competency conference about the importance of developing measures to track progress. To this end, NICHQ developed core measures focused on outcome, process, and structure. Some of the measures accounted for differences among racial or ethnic groups in key clinical outcomes, as well as the percentage of patients receiving care in their preferred language. NICHQ found that providing interpreters resulted better communication, more appropriate diagnosis, and a deeper understanding of patient needs.

Two other case studies—L.A. Care Health Plan and the Children's Hospitals and Clinics in Minneapolis and St. Paul—also demonstrate the importance measuring changes. Throughout L.A. Care's process of implementing cultural competency initiatives, Beatriz Solís, M.P.H., the organization's former director of cultural and linguistic services, collected data to share with management, staff, plan partners, and external stakeholders. This information demonstrated the positive impact of the projects, such as increased employee satisfaction after cultural competency trainings. Children's Hospital found that measuring the benefits of cultural competency to patient safety efforts, through the filing of patient safety reports, reinforced the sustainability of efforts.

Measuring the results of cultural competency efforts is critical to a project's success and sustainability. While some organizations may be able to implement large-scale, major initiatives, smaller, more incremental changes may be easier to justify, measure, and maintain.

Principle 4: Making the business case is a critical element for change. Making a strong business case is a powerful motivator for incorporating cultural competency, but doing so can be challenging. For example, it may be difficult to prove that an organization will pay more in the future for care not currently provided. The business case must take into account the benefits of providing culturally competent care to patients

and the community. More importantly, it is vital to broaden the widely accepted notions of what constitutes the business case, and what constitutes the benefits of providing appropriate care. From a societal perspective, this may include the long-term benefit to patients and community.

At CPEHN's conference, a discussion about cultural competency's effect on the bottom line elicited the following suggestions: develop and implement cultural competency organizational assessments; implement a bonus structure; encourage organizations to share positive results with other leaders to spur competition; and present data that show the relationship between patient and job satisfaction and cultural competency.

At L.A. Care Health Plan, for example, internal staff satisfaction data were used to make the business case for cultural competency trainings. Results from an employee survey showed employees with more direct member contact were less satisfied and more pessimistic. Findings were then shared with leadership, along with a proposal for staff cultural competency trainings. The satisfaction survey data was critical to identifying the need for the trainings and getting the commitment and resources for implementing and evaluating the trainings. The director of cultural and linguistic services collected data and used the quantifiable deterioration in staff morale as a springboard to motivate the leadership to take action.

Other case studies also demonstrate the need for making the business case. NICHQ's Nicole Reavis found that making the business case by citing research data and the health disparities literature was critical to getting a clinic to understand the importance of cultural competence—even in a project that was funded through a foundation and framed within a well-known quality improvement model.

A business case can be made using many different types of information. Some cultural and linguistic champions have used published literature about health disparities and the ability of language services to improve access and utilization to services to justify their projects. Others have collected internal data about patient, provider, or staff satisfaction to make their case.

Finally, health care organizations should recognize that capturing greater market share in the rapidly diversifying communities of this country require that they respond better to the unique needs of communities of color.

Principle 5: Commitment from leadership is key factor to success. Commitment of leadership is perhaps the most significant element in an organization's ability to integrate cultural competency. While initiatives and support for cultural competency need not come from the top, full involvement from top levels of management will create the greatest impact. Leaders must also be engaged to create an atmosphere in which others in the organization have the authority and resources to initiate and implement improvements.

If leadership is not convinced and committed to cultural competency efforts, it is difficult to gain staff buy-in and resources needed for successful implementation. Health care organizations can create leadership commitment by ensuring that the diversity of staff reflects the population served. OMH CLAS Standard 12 states: "Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristic of the service area." Having a diverse workforce not only helps an organization provide culturally and linguistically appropriate services, it also promotes an environment where the services are valued.

In the LEAD case study, the project required CEOs of each participating hospital to sign a letter of commitment for the hospital to receive funding. Sunita Mutha, M.D., LEAD program director, noted that commitment from leadership was critical to the success of the project. The effort resulted in some CEOs becoming cultural competency champions who were able to speak effectively to other hospital administrators about their successes.

Unlike the other case studies, Woodhull Medical and Mental Health Center successfully implemented large-scale, major cultural competency changes within its organization, largely due to the strong commitment of the CEO. During a time of transition, Woodhull hired a new CEO dedicated to implementing changes using OMH's CLAS standards. When asked how well the cultural competency efforts would be sustained if there were a change in leadership, Stephen Bohlen of the Business Affairs Department at Woodhull Medical and Mental Health Center said that cultural competency is so well integrated into the existing system that it would be difficult to eliminate, even if a less-supportive CEO were to take over.

The most successful cultural competency efforts have had commitment from the organization's leaders. Organizations must ensure that the leaders they hire value diversity. Once these individuals are in place, they can be cultivated by other leaders or

advocates in the organization and become champions for cultural competency, sharing their lessons learned and successes to advance the field.

Principle 6: Staff training is necessary on an ongoing basis. Interviews confirmed that continuous staff training is an essential component of successful cultural competency programs. Staff training ensures buy-in based on an understanding of why changes are necessary and builds staff capacity to successfully implement the project. Furthermore, familiarity with patients' cultures helps promote an environment of understanding and appreciation for diversity, and it allows for more successful follow-through. The importance of staff training is reflected in OMH's CLAS standard 3, which states that: "Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery."

At CPEHN's cultural competency conference, conference speakers and participants agreed that the collection of race, ethnicity, and language data is important but difficult to achieve. Speaking of her experiences planning and implementing a citywide health disparities initiative, Monica Valdez Lupi, chief of staff for the Boston Public Health Commission, said that registrars were just as reluctant to collect patient data as patients were to provide the information. However, after staff received sensitivity training and were provided scripts to use, patients were more likely to share information, because they understood that it was being collected to provide equitable care.

Speaking about the NICHQ project, Nicole Reavis said that when evaluating the project, they found that clinic staff were uncomfortable asking patients for race information if they did not understand the purpose of collecting it and were not trained on how to appropriately ask questions. Appropriate training addressed this challenge, and staff exposure to cultural norms increased their comfort in handling issues related to diversity.

Beatriz Solís of L.A. Care Health Plan emphasized the importance of training in increasing staff morale and ensuring quality of care. A key element of training is to ensure that staff are comfortable and understand the changes occurring in the organization. When staff understood how simple it was to arrange for an interpreter, for example, they were not uncomfortable when members requested one and were more likely to coordinate the necessary services.

Staff training is clearly a critical component of a successful cultural competency initiative. Training not only provides an important forum to discuss diversity issues, it also helps gain staff buy-in and understanding of cultural competency efforts. Lastly, ongoing training gives staff the information, tools, and skills necessary to successfully implement changes.

CASE STUDIES: IMPLEMENTING CULTURALLY COMPETENT SYSTEMS

Case Study 1—National Initiative for Children's Healthcare Quality

Organization/Project: The National Initiative for Children's Healthcare Quality (NICHQ)—an organization that works to improve the quality of children's health care—conducted a project funded by The California Endowment to integrate quality improvement and cultural competency in clinics. The objectives were to: create a strategy for improving cultural competency in children's health care within a specific framework used in most of their quality improvement projects; develop practical strategies that health care organizations (primary care practices, in particular) can use to better care for diverse populations; and develop measures that can be used to track progress towards the goal of culturally competent care. Nicole Reavis, M.Ed, is the project director.

Process of Change: The purpose of the project was to gain an understanding of the feasibility and usefulness of strategies proposed to achieve changes in quality. The organization convened an expert panel to develop a series of potential strategies to improve cultural competency and create community partnerships. The strategies included: assessing community demographics and needs, developing liaisons with community leaders, providing culturally competent care at all points of contact, designating staff responsible for overseeing changes, and using standardized instruments to assess health literacy. NICHQ then surveyed providers to see if they had already undertaken any of the proposed strategies and what the successes and challenges had been. Providers were also asked to try out the strategies to test their effectiveness. Some of the pilot test findings include:

- Providing trained interpreters—even by telephone—resulted in better communication, more appropriate diagnosis, and a deeper understanding of patient needs.
- Staff exposure to cultural norms increased comfort in dealing with diversity and the use of more effective treatment plans.
- Capturing data about race and ethnicity enabled programs to examine and address gaps in practice.

Challenges and obstacles included the cost of providing interpreter services and the discomfort of frontline staff about collecting race and ethnicity information.

Lessons Learned: Many clinics in the projects had difficulties integrating cultural competency into their systems. Often, clinics needed more exposure to the business case for improved cultural competency as encouragement. Development of data collection systems was one of the key strategies pursued by clinics. The collection of data proved challenging for line staff—they felt uncomfortable asking questions about race and did not understand the purpose of collecting the data. In addition, some staff felt that they did not have cultural competency issues if their limited-English-proficient populations were, for instance, ethnic Russian and not considered minority. They believed that as long as language services were provided, those community needs were addressed. There was a wide variation in the level of knowledge of the issue from clinic to clinic, with the clinic size often determining its ability to commit resources to undertake improvements; larger clinics had more resources to undertake changes. While the clinics generally understood and were committed to the need for language services, they did not always fully understand their role in ensuring the competency and training of interpreters.

Motivation for change was usually prompted by an awareness of changes in the communities, though outside funding was also a motivating factor, as was literature about health disparities. Key factors to success were: providing interpreter services at all points of contact; data collection; exposing key staff to the cultural norms of the target patient population; and meeting with key community leaders who are respected by the patient population.

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Case Study 2—L.A. Care Health Plan

Organization/Project: L.A. Care Health Plan is a non-profit health maintenance organization that serves more than 750,000 Los Angeles county residents who participate in the Medi-Cal and Healthy Families programs. At L.A. Care, cultural competency was integrated into the mission, values, and goals. Beatriz Solís, M.P.H., served as director of cultural and linguistic services until 2005.

Process of Change: L.A. Care focused on hiring from the community. According to an employee survey, staff with more direct member contact reported lower satisfaction with their jobs than staff with less direct contact. Results were presented to the plan's leadership, along with a proposal for staff cultural competency trainings. The data from the employee survey was critical in identifying the need for the trainings and getting commitment and resources for their implementation and evaluation. The response to the trainings was overwhelmingly positive, and data from post-training evaluations made the case to reevaluate personnel practices and institutionalize the cultural competency trainings.

Staff without direct patient contact were resistant to the training because they did not feel such contact was relevant to their work. One key to success is to counter the feeling that cultural competency will create new or more work. Avoiding staff burnout is important. The trainings should provide a feeling that the new tools will make jobs easier, more effective, and rewarding. Staff must know where they can get help if they are struggling with the issues, making it critical for organizations to have staff dedicated to improving cultural and linguistic access. In fact, L.A. Care added a requirement in their contracts with plan partners—which provide services to the majority of their members—that they must have staff dedicated to these issues. These changes came about as a result of audits of plan partners, which found poor performance in their integration of cultural competency. Other steps included developing regional advisory committees to provide communities with a way to provide input on plan operations and services. The committees had their own budgets, which allowed for the necessary resources and trainings.

Lessons Learned: Monitoring and benchmarking are critical. Every staff position and every change must be justified with data. In addition, the most effective impact comes from the top down. Leadership must be committed to the process, even if they must be prompted by exposure to data or the business case.

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Case Study 3—Children's Hospitals and Clinics in Minneapolis and St. Paul, Minn.

Organization/Project: Children's Hospitals and Clinics of Minnesota is the eighth-largest children's health care organization in the United States, with 319 staffed beds at its two hospital campuses in St. Paul and Minneapolis. It is an independent, not-for-profit health care system, providing care through more than 13,000 inpatient visits and more than 200,000 emergency room and other outpatient visits each year. Boris Kalanj, M.S.W., L.I.S.W., is director of the cross-cultural care and interpreter services department. The department's mission and goals include: provision of language access services, workforce education, and building better data collection, evaluation, and research capacities related to access and quality of health care for patients and families with limited English skills.

Process of Change: Over the past five years, the number of full-time staff interpreters increased from two to 14. The hospital created a department for interpreter services and hired a manager. In addition, the hospital began using interpreters as cultural mediators—a change that addresses cultural competency in addition to language access. This allowed the interpreters to act as a patient advocate in the room during the encounter between patient and provider. Though some providers have not been happy about having a third party in the patient encounter, most appreciate the cultural mediation provided by interpreters. The organization has just begun a survey process to evaluate the program, but anecdotal evidence shows patients' reaction is overwhelmingly positive. According to Boris Kalanj, many patients have described experiences that would not have gone as smoothly had the cultural mediator/interpreter not been present. In addition, the hospital has implemented a measurement system that makes it easier to file a safety report and has encouraged staff to do so. There has been a noticeable decline in reports filed related to language access.

The organization was motivated to make changes because of two factors. First, in the community, advocates had filed lawsuits against other organizations related to access issues for deaf patients. Second, new leadership, including Kalanj, came on board with a commitment to language access issues. Though the positive changes were primarily the result of a committed leadership driven to action, the new processes are now well-integrated and would be protected against changes in leadership. Better services become ingrained in the organization, and new leadership would not want to eliminate these improvements. In addition, when patients and providers become accustomed to a certain level of services, it would be difficult to eliminate them.

There has also been a growth in the number of LEP patients as word of the organization's efforts has spread. This was partially deliberate: the organization hired community outreach workers to talk to members of the community, particularly among Somali, Latino, and refugee communities. The outreach workers were responsible for getting feedback on ways to improve services and communicating the positive changes already implemented. Doing this increased community demand, making it hard for the organization to reduce its commitment to providing culturally competent services.

Lessons Learned: Cultural competency efforts must have the support of senior leadership. Educating these leaders about the issues of health disparities and unequal treatment can help. Also, change comes slowly and measurement is crucial—the organization must collect data and understand patients' needs. Hospitals can learn from each other and should connect on these issues.

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Case Study 4—Woodhull Medical and Mental Health Center

Organization/Project: Woodhull Medical and Mental Health Center, located in Brooklyn, N.Y., is a hospital with more than 400 beds. Stephen Bohlen, Esq., works in the hospital's business affairs department. Changes at Woodhull began in late 2000.

Process of Change: Cultural competency is incorporated into the organization's mission, framed as a patient safety and customer service issue. The hospital has begun using staff interpreters, with a telephone language line vendor as backup. The organization asks all patients what their language preference are and if they need an interpreter. Cultural competency trainings are held for various departments, with the training of competent medical interpreters being top priority. Cultural competency training is also incorporated into the corporate-wide, five-day orientation for new hires, and there is an annual in-service training on cultural competency. Race and ethnicity information is collected and placed in the patient record.

Contrary to information gleaned from other case studies, Woodhull embarked on adopting large-scale, rapid changes. In a situation similar to the one at Children's

Hospitals and Clinics in Minneapolis and St. Paul, local advocacy groups were making complaints and filing lawsuits against providers in the area. At the same time, Woodhull acquired a new CEO who was committed to implementing changes using the OMH CLAS standards. Organizations that make such rapid, wholesale changes may be quick to backslide when there are financial difficulties or leadership transitions. However, according to Bohlen, the changes are well integrated into the system and would be hard to eliminate, even if a less-supportive CEO were to take over.

Providing language services was the organization's biggest success. It hired providers who speak Spanish and Polish , took steps to ensure patients were asked about their language needs by posting reminders for staff, and redesigned signage throughout the hospital. The hospital also gained buy-in from staff and providers. While there was some initial reluctance by providers to use interpreter services, this resistance was overcome as providers became more familiar with the procedures. Providers were asked to document encounters in which interpreters were used. The hospital also tried to eliminate the practice of using administrative staff as interpreters during medical encounters. A survey of providers found satisfaction has increased after these changes were implemented. As part of a goal to diversify the workforce, 70 percent of staff are hired from the community. There is also a new system to solicit community feedback. A community advisory board—half of whose members are patients—meets monthly. The hospital also uses satisfaction surveys, and staff has been meeting with community members, including uninsured day laborers—who are a large part of the patient population—to get a better understanding of the needs of the community to allow the organization to respond effectively.

Lessons Learned: Strong leadership is crucial, both administrative and clinical. Framing cultural competency as a safety issue is helpful, as are overlapping frameworks for patient safety and quality. Available resources for implementing the changes are also critical. It may be helpful to take an integrated approach, making changes in many areas at once.

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Case Study 5—LEADing Organizational Change: Advancing Quality Through Culturally Responsive Care

Organization/Project: The LEADing Organizational Change: Advancing Quality through Culturally Responsive Care (LEAD) program, supported by funding from The California Endowment, is a three-year initiative to enhance the quality of care among California's public hospitals by assisting them—through education and funding—in implementing changes to improve the delivery of culturally appropriate care. The program's four components are: leadership, education, accountability, and dissemination. LEAD was developed by the Center for the Health Professions, in partnership with the California Health Care Safety Net Institute, the education and research affiliate of the California Association of Public Hospitals and Health Systems. Sunita Mutha, M.D., is program director of the Center for the Health Professions, at the University of California, San Francisco.

Process of Change: LEAD Project funding can be a motivator for hospitals to implement cultural competency, however, according to interviews with Dr. Mutha, money was not the primary motivator, as most of the hospitals had been discussing making changes to adapt to the increased diversity among the patient population. The hospitals in the program are self-selected and must demonstrate a commitment to the process before becoming eligible to participate. Hospitals applied for one-year grants and technical assistance to improve the cultural competency of services. In order to participate, the CEO of each hospital had to sign a letter committing to the program.

LEAD is founded on the principle that cultural competency is a quality-of-care issue, and that organizational change, leadership, and sustainable infrastructure are essential components of success. Hospitals are receptive to the quality framework, and also clearly see the changes occurring in the diversity their patient population.

Lessons Learned: Having examined the experiences of participating hospitals, Mutha advises organizations not to take on too much too soon or take a very broad perspective. The organizations that did so were among the least successful. She presents the Institute for Healthcare Improvement's rapid cycle as an appropriate for change: make small changes, evaluate, refine. Small changes will then lead to larger ones. The most successful hospitals understood they had to focus on one project.

Hospitals did not always find ways to quantify and document their successes in improving services, which is unfortunate, as this is an essential component in demonstrating success. Data are important—even anecdotal information can have value.

At successful hospitals, there were usually internal champions—not necessarily in top leadership, although CEO buy-in was critical. Pressure or influence from accreditors, like the Joint Commission on Accreditation of Healthcare Organizations, can make a difference in hospitals' interest in undertaking cultural competency initiatives, as can pressure from advocates. Hospitals find community-responsiveness difficult and daunting, or approach it too loosely, by merely conducting a patient survey, for instance. LEAD encourages hospitals to find advocacy organizations to assist them in becoming more community-centered. Mutha also advises that larger organizations will have an easier time implementing changes because of their greater resources.

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Use of Cultural Competency Principles by Case Study Organizations

Case Study	Principle 1. Community representation and feedback	Principle 2. System integration	Principle 3. Sustainability (i.e., incremental change, measuring outcomes)	Principle 4. Business case	Principle 5. Leadership	Principle 6. Staff training
NICHQ	Change spurred by awareness of shifting demographics in the communities. Met with key community leaders.		Capturing data about race and ethnicity enabled programs to examine and address gaps in practice.	Needed more exposure to arguments for the business case to encourage the clinics to do more.		Staff exposure to cultural norms increased comfort in dealing with diversity.
L.A. Care Health Plan	Developed regional advisory committees.		Data was critical in identifying the need for staff trainings and getting commitment and resources for implementation and evaluation.	Bottom-up impact is very limited. Leadership must be committed, and may need exposure to data or the business case.	Data presented to leadership was imperative for change.	Counter feelings that more work is being created. Dedicate staff members to cultural competency efforts throughout programs and departments in the organization. .
Children's Hospitals and Clinics of Minnesota	Hired community outreach workers to market services and solicit feedback.	Utilizing interpreters as cultural mediators. Encouraging staff to file safety reports when an interpreter is not present.	Survey process to evaluate the cultural mediation program. Experienced growth in number of LEP patients. This increased community demand, making it hard to reduce commitment.	Saw an increase in the number of LEP patients as a result of improved cultural and linguistic services..	Changes made, in part, because of new leadership.	
Woodhull Health Center	Monthly meetings of a community advisory board, satisfaction surveys, staff meetings with community members.	Incorporate cultural competency into mission, framing it as a patient safety and customer service issue.	Race and ethnicity information collected and placed in the patient record. Survey found provider satisfaction increased since changes implemented.		Acquired new CEO committed to implementing CLAS standards.	Incorporate cultural competency training into corporate-wide orientation for new hires.
LEAD	Project encourages hospitals to find advocacy organizations to assist them in becoming more community-centered.	Project founded on principle that cultural competency is a quality of care issue.	There were struggles for hospitals that could not narrow their goals or evaluate whether implemented changes had been successful.	Hospitals see changing demographics o patient population.	To participate, CEOs had to sign a letter committing to the program.	

RECOMMENDATIONS FOR ADOPTING THE PRINCIPLES AND TURNING THEM INTO ACTION

Principle 1—Community representation and feedback is essential at all stages.

- Organizations must have ways to interact with community groups and must seek out community leaders to solicit their concerns and recommendations on ways to improve services.
- Community involvement in decision-making, evaluating community satisfaction, and assessing improvements in health status must be ongoing. Community must not only be invited to the table, but must be given the tools to meaningfully participate. Strategies may include: satisfaction surveys in multiple languages, advisory committees with buy-in from the leadership, facilitating meaningful participation by providing training, stipends, or child care.
- Measuring the level of community support and having effective liaisons from the community will help ensure the changes are sustainable and not decreased in times of budget cuts or leadership transition.
- Community values must be respected. Organizations must make a commitment to create an environment that builds trust with the community and does not exploit it for token support.

Principle 2—Cultural competency must be integrated into all existing systems of a health care organization, particularly quality improvement efforts.

- The organization's mission must incorporate a commitment to cultural competency.
- Cultural competency must be a component of disease management, quality improvement, patient safety, customer service, and patient–provider interaction.

Principle 3—Changes made must be manageable, measurable, and sustainable.

- From the beginning, organizations must consider how they will evaluate and quantify the positive impact of their cultural competency efforts.
- Organizations that take on too many large-scale changes at once will have trouble measuring impact.

Principle 4—Making the business case is a critical element for change.

- The business case must be explored, taking into account the social benefits of providing culturally competent care, the diversifying patient population, improved market share, and decreased liability.
- External actors must apply pressure to organizations to create change. This may include lawsuits brought by advocacy groups, requirements from accreditors or government agencies, or funding provided by foundations. All stakeholders have a part to play in encouraging organizations to improve the cultural competence of their care.

Principle 5—Commitment from leadership is a key factor to success.

- Organizations must recruit a diverse workforce and a diverse leadership committed to equality in health care. Diversity at the leadership level will establish understanding and support for cultural issues experienced at the patient–provider level.
- Existing leaders who have implemented cultural competency in their organizations must share their experiences and become spokespeople for advancing the field.

Principle 6—Ongoing staff training is crucial.

- Staff should be familiar with the community and its cultural norms. Staff trainings should contain an element of cultural competency education.
- Leadership must support staff trainings by dedicating time and resources to implementation, and ensure that the regular scheduling is incorporated as formal policy.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality (October 2006). Mary Catherine Beach, Somnath Saha, and Lisa A. Cooper.

Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care (October 2006). Joseph R. Betancourt.

The Evidence Base for Cultural and Linguistic Competency in Health Care (October 2006). Tawara D. Goode, M. Clare Dunne, and Suzanne M. Bronheim.

Cultural Competency and Quality of Care: Obtaining the Patient's Perspective (October 2006). Quyen Ngo-Metzger, Joseph Telfair, Dara Sorkin, Beverly Weidmer, Robert Weech-Maldonado, Margarita Hurtado, and Ron D. Hays.

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Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals (August 2006). Matthew Wynia and Jennifer Matiasek.

Patients' Attitudes Toward Health Care Providers Collecting Information About Their Race and Identity (October 2005). David W. Baker, Kenzie A. Cameron, Joseph Feinglass et al. *Journal of General Internal Medicine,* vol. 20, no. 10 (*In the Literature* summary).

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Providing Language Services in Small Health Care Provider Settings: Examples from the Field (April 2005). Mara Youdelman and Jane Perkins.

Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals (May 2004). Romana Hasnain-Wynia, Debra Pierce, and Mary A. Pittman.

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