



ISSUE BRIEF

The Massachusetts Health Policy Forum

CULTURAL COMPETENCE AND HEALTH CARE IN MASSACHUSETTS

WHERE ARE WE? WHERE SHOULD WE BE?

Thursday, July 15, 1999

8:30 to 9:00 – Breakfast

9:00 to 11:00 – Presentation & Discussion

Omni Parker House Hotel

School and Tremont Streets

Boston

Registration: Please call Sue Thomson at 617-338-2726 as soon as possible

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Introduction

The rapid growth of the non-White population in Massachusetts during the last decade mirrors that of the U.S. population with racial/ethnic minorities in 1995 making up 27% of the total population. Forty percent of the U.S. population will be immigrants or first generation Americans by the year 2000. Estimates predict that racial/ethnic minorities in the U.S. will make up 48% of the total population by 2050; 14.4% will be Black, 22.5% Hispanic, 9.7% Asian American, 0.9% American Indian, and 52.5% White.¹ This does not include new migrations from Europe.

The growing diversity of the U.S. population is reflected also in the heterogeneity within racial/ethnic minority groups. Blacks include African Americans, Haitian Creole, and other Caribbean groups, while Hispanic or Latino Americans include individuals from South America, Central America, Mexicans, Cubans, Puerto Ricans, and others. Asian Americans include over 40 groups, with the most common in Massachusetts being Chinese, Vietnamese, Cambodian, Korean, Filipino, Japanese, and Indian. Native Americans include 365 tribes, with the Wampanoag and Micmac tribes being most common in Massachusetts. Each of the racial/ethnic groups has emphasized the significant heterogeneity within groups with respect to population demographics and health risk factors.²

Each racial/ethnic group has sought to eliminate the adverse effects of racism and stereotypes while supporting the importance of attending to unique group differences. The prevalence of negative stereotypes for Blacks and Hispanics and the adverse effects of the healthy model minority myth for Asians have resulted in discriminatory practices in service delivery and resource allocation for all of these groups. Yet, it is clear that the sociopolitical context of poverty, racism, immigration, and culture has had a significant bearing on health status, health care utilization, and access to care for all racial/ethnic groups.

Movement From Cultural Sensitivity to Cultural Competence

Demands for cultural competence arose out of the failures of the service delivery system to be responsive to all segments of the population. Initially, an emphasis on cultural sensitivity was stressed when providing services to ethnic minorities and culturally different groups, especially given language and cultural barriers faced by non-English speaking immigrants/refugees, and racial and economic barriers faced by ethnic minorities. While this meant responsiveness to cultural differences in attitudes, behaviors, beliefs, values and lifestyles as well as language, the system continued to fail for these underserved groups. The community health and mental health movements dovetailed with the Civil Rights Movement of the '60s, giving voice to the dilemma of agencies and communities grappling with the availability of services to ethnic minorities and low income populations.

During the '80s, this focus on cultural sensitivity shifted to a demand for cultural competence, i.e., a *skill-focused paradigm*, over one of mere sensitivity. While the use of bilingual/bicultural providers and the importance of familiarity with the culture of one's clients continued to be stressed, this transformation to a skill-focused paradigm resulted in efforts during the '90s to operationalize and define those components necessary to achieve cultural competence.

As managed care and health care reform efforts grew during the '90s, advocates of cultural competence expressed a growing concern that the small gains made by institutions and agencies within the health care delivery system in the previous decade to become culturally competent could now be lost. In an environment of cost containment, many fear that cultural competence as a priority would be subordinated to economic and market incentives.

Defining Cultural Competence

Cultural competence was initially defined by the Children and Adolescent Service System Programs (CASSP) initiative in its seminal monograph, *Toward a Culturally Competent System of Care*³ in 1989. Developed as a model for services to minority children who are severely emotionally disturbed, it emphasized a systems perspective consisting of four levels:

- Policy making
- Administrative

- Practitioner
- Consumer

The CASSP defined cultural competence along a developmental continuum from cultural destructiveness to cultural proficiency as:

*"A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to culturally unique needs."*⁴

Many definitions of cultural competence have since emerged, often focused on the process necessary to achieve it, or the criteria to decide if it exists. The California Cultural Competency Task Force, established in 1993 by its Department of Mental Health is one such example. It defined a culturally competent process as one,

*"which requires individuals and systems to develop and expand their ability to know about, be sensitive to, and have respect for cultural diversity. The result of this process should be an increased awareness, acceptance, valuing and utilization of and an openness to learn from general and health related beliefs, practices, traditions, languages, religions, histories and current needs of individuals and the cultural groups to which they belong. Cultural competency is appropriate and effective communication which requires the willingness to listen to and learn from members of diverse cultures, and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of an individual's cultural health beliefs and practices."*⁵

Other definitions have delineated overarching principles necessary for institutions and providers if they are to provide culturally competent services. The state of Washington issued a blueprint for providing a framework⁶ while other definitions include: principles of diversity and difference,⁷ conceptualizations of organizational change,⁸ operationalization of multicultural counseling competencies,⁹ attending to culture in diagnosis using the DSM IV,¹⁰ guidelines for counseling the culturally different,¹¹ developmental models,¹² and self-reflection models.¹³

Yet, there is a general sense that few providers have thought about biases they may bring to patient encounters or about their own cultural/ethnic background, health beliefs, and practices. Their goal is often to get the patient to conform to the mainstream, and not to meet them on their cultural ground. In medicine, this quickly translates into patient attitudes about health which will affect compliance, traditions, and views of religion and death which will influence attention to discussion of disease and disease management, views of race and power which will influence the nature of the communication between doctor and patient.^{14,15}

While health care providers have been urged to be cognizant of cultural traits, religious beliefs, concepts of health, and health practices that are uncommon in Western medicine, the following scenarios illustrate only some of the issues that may arise.¹⁶

- Prescribing practices: A physician prescribes medication without knowing or asking about the patient's use of an herbal medicine that has adverse interaction effects.
- Erroneous translation: A Latino client says her child is "se me enfermo" which was translated as "he got sick." The physician does not realize the seriousness attached to this and dismisses it as inconsequential.¹⁷
- Poorer access for non-English speaking patients: A Latino immigrant diagnosed with chronic back pain and an ulcer is referred to a hospital for a special test; she complains that she would rather die than to keep going. "First, I have to wake up early in the morning, leave home about 7AM for the hospital. I wait and wait to have this special test, and come home by 4PM. A translator is not always available. I think the test takes only ten minutes, but I have to wait 5-6 hours."

- Folk remedies used by Asian American groups misunderstood by providers: A Cambodian refugee uses cao gio or coin rubbing to dispel the "bad wind," or to restore natural balance between hot and cold elements of the universe, when her daughter is feverish. The bruise left by this remedy is reported as abuse by the provider.
- Mistrust of the health care system and providers: An African American patient does not return after he is told of a new experimental procedure to be used for his condition. He is afraid that he will be used in experimentation like the subjects in the Tuskegee syphilis experiments.

Cultural Competence in Health Care

While many of the cultural competence initiatives originated in the mental health arena, these quickly mushroomed into the health arena as well. Increasingly, the need for providers and service delivery systems to be culturally competent has become pressing, fueled by economic imperatives. As advocacy groups challenge the system to serve diverse segments of the population, and as ethnic minorities grow in market share, there is economic value in marketing to a diverse population. Diversity and cultural competence have become buzzwords for good business while also satisfying affirmative action objectives.

Nevertheless, cultural competence has yet to achieve a status as being integral to health professions training,¹⁸ or essential to standards of professional practice. The relevance of individual and cultural bias, and provider and institutional values as they influence health care utilization, service delivery systems, and lifestyle behaviors has yet to be recognized. Discussions of cultural competence in health care generally have been limited to language access or the ability of providers to communicate with their patients.

How is cultural competence different in health care? While cultural competence slowly made its way into the language and practices of the health care delivery system, this varied across specialties. Technology-based specialties were less likely to see cultural competence as relevant to its practice while community health and primary care settings were more likely to view it as important given the more direct interface with patients, families, and communities.

IMPACT OF TRENDS IN HEALTH CARE

National trends within health care have had a significant impact on the evolution of cultural competence within health care. Many of the changes in reimbursement and in the marketplace nationally have been mirrored within Massachusetts.

Racial Disparities

Cultural competence has been intricately interwoven with minority health premised upon the importance of appropriate disease management and prevention as it relates to the population. Consequently, the presence of racial disparities in disease incidence, prevalence, and health status suggests a system that has not been responsive to all segments of the population.

The 1985 Report of the Secretary's Task Force on Black and Minority Health¹⁹ began the discussion on racial disparities in health. While Blacks and Hispanics demonstrated significant disparities from Whites on the six leading causes of death, Asian Americans and Native Americans did not even appear on the charts, "suggesting their good overall health." While this report on racial disparities has been positive in drawing national and local attention to improving Black and Hispanic health status, it has been challenged for ignoring significant and meaningful disparities among other ethnic minority groups. Asian American and Native American groups, in particular, have criticized its inadequacies in masking significant differences among those racial/ethnic groups who make up a disproportionately smaller share of the population. This resulted in few of the Healthy People 2000 objectives targeting these groups.²⁰ The public health datasets upon which this report is based have also been challenged because of their failure to disaggregate racial/ethnic groups, insufficient sample sizes to allow meaningful analyses,²¹ inadequate sampling methods, and selection bias in identifying diseases relevant and specific to ethnic minority populations.

A major criticism of racial disparities has been the use of a comparative paradigm in which minority health is defined against a White standard. This comparison ignores other significant trends and differences in health status not found within the White populations; it has adversely resulted in creating and sustaining stereotypes that result in ignoring the health needs and relevant indicators of health status among ethnic minority

populations. For example, while hepatitis B and tuberculosis carrier rates among Asian Americans were more than ten times greater than in the White population, they did not make the list of indicators.

The National Comparative Survey of Minority Health Care in 1995,²² in fact, showed that minority adults from all four racial/ethnic groups, i.e., Black, Hispanic, Asian, and Native American, are twice as likely as Whites to be uninsured. In addition, they are more likely to experience difficulties in receiving appropriate and needed medical care, they have less choice as to where they receive care and less access to regular sources of care, and, they report more negative experiences with the health care system.

In February 1998, President Clinton announced an Eliminating Racial Disparities Initiative that set a national goal to eliminate longstanding disparities in health status among racial/ethnic minority groups by the Year 2010.²³ Calling for collaborative public-private partnerships, this effort dovetails with President Clinton's Race Initiative, which recommends a "blueprint for national policy to eliminate racial disparities, to bridge the racial divide, and to value diversity in embracing common values."²⁴ These initiatives, in turn, dovetail with the Healthy People 2010 initiative of the U.S. Department of Health and Human Services, the overall goal of which is to improve the health of all Americans through disease prevention.²⁵

State and local health departments have responded to these initiatives to eliminate disparities in health status. Governor Michael Dukakis appointed a task force to examine low birthweight and infant mortality in 1990; this resulted in a major federally funded Healthy Start Initiative in Boston to address the disproportionate rates of infant deaths within Black and Hispanic communities during the '90s. These issues were revisited in 1997 through the Mayor's Infant Mortality Summit in Boston. The National Association of County Health Officials' Multicultural Health Project²⁶ paired health departments with community-based organizations to increase access to care for targeted populations, stressing the importance of collaboration. Most recently, the Massachusetts Department of Public Health, Office for Minority Health began a strategic planning process in 1996, and has formed a Minority Health Advisory board that will help the department address health disparities.

Population Demographics

The measurement of health status, service utilization, quality and access to care has been critical to identifying the health of the nation's population and its communities. Typically, national and state public health datasets have used global indicators as a basis for policy planning, program development, and resource allocation. With the growing diversity of the U.S. population, racial classification and the use of ethnic identifiers have become significant variables within these datasets.

The use of ethnic identifiers, i.e., who makes up the population, enables policymakers, payers, and service providers to target interventions to specific population needs, and therefore, reflects cultural competence. The ability of a system of care to identify patterns of utilization, quality, and access for different racial/ethnic groups is important because there exist differential prevalence patterns and epidemiologic rates of disease. It also reflects the growing belief that a uniform standard based on the White population can no longer be the norm for public health indicators, and that data needs to be disaggregated for meaningful analysis and competent health planning. The U.S. Census recently increased the number of racial/ethnic classifications for the 2000 census, and will allow for multi-racial classifications. In Massachusetts, the Department of Public Health compiled Latino and Asian databooks on births in 1993 toward this effort.²⁷ The City of Boston also began to collect data on race/ethnicity in its *Health of Boston* report.²⁸

In general however, public health datasets typically do not disaggregate ethnic groups, or are insufficient in identifying racial group differences, therefore losing the opportunity for meaningful analysis. Racial/ethnic data, if available, tend to be limited to White, Hispanic, and Black. Native Americans and Asian Americans are generally excluded, as well as significant subgroups within the Hispanic and Black populations, e.g., Haitian Creole. The Latino Coalition for a Healthy California, and the Asian Pacific Islander American Health Forum at the national level, and the Latino Health Data Consortium in Massachusetts have supported initiatives to disaggregate data.

Growing Integration of Services

The rapid growth of managed care, privatization of services, increased competition within the tertiary care system, and health care reform provided the impetus for rapid change in the health care environment. This influ-

enced a growing integration of services between primary and tertiary care, between health and mental health care, between hospitals and community-based systems, etc. Several factors have contributed to a growing integration of these systems of care.

Emphasis on cost containment resulted in a rapid growth of managed care with over 40% of Massachusetts residents now enrolled in health maintenance organizations (HMOs), compared to its near absence in the '80s. As primary care providers became the gatekeepers of services within a managed care system, hospital systems needed to restructure themselves to maintain market share. The development of hospital networks and integrated systems became a means to survival, and competition for covered lives grew as a means to maintain market share. During the '90s, hospital closings and mergers involved all the major players in Massachusetts in response to changes in the marketplace and reimbursement mechanisms.

Health and mental health systems, which have historically been separate, are now also being integrated in response to these trends. A growing recognition of psychosocial influences on lifestyle behaviors, patient compliance, and disease management and evidence that the onset and course of chronic disease conditions can be modified by lifestyle behaviors have resulted in a growing emphasis on prevention and patient education. The influence of sociocultural factors on lifestyle behaviors, and racial/ethnic differences in health beliefs, lifestyle behaviors, and health behaviors make this an issue of cultural competence.

A growing consumer movement has also contributed to a growing integration of services with emphasis on consumer choice and consumer empowerment. Consumer participation in health care decision making, emphasis on patient satisfaction, and expanded benefits to include acupuncture respond to consumer demand. With changing population demographics, wholistic health beliefs, common among many ethnic minority communities, have resulted in a demand for mind-body approaches to health care and traditional health care methods such as herbal medicine. Providers, hospitals, and payers, alike, are beginning to realize the economic value of accommodating a diverse population in order to capture market share. Growing interest in alternative medicine has extended to the majority population, creating greater consumer demand for such products and services beyond that of racial/ethnic communities.

Megaproviders and Networks

As Massachusetts began to privatize its purchase of services, the emergence of megaproviders, coalitions, and networks also became the means by which to gain a place at the table for negotiating contracts and rates in human services. With the growing integration of services, size has become increasingly important for survival. "Mainstream institutions" and megaproviders increasingly are partnering with community-based organizations to gain access to minority communities and ethnic-specific providers. The resources of large institutions and access to minority communities have created attractive partnerships.

The ability of megaproviders and networks to mirror and be responsive to their designated communities is becoming an economic imperative, representing a shift from the charitable obligation of non-profit hospitals under community benefits. The Massachusetts Attorney General (A.G.) issued voluntary Community Benefits Guidelines for Nonprofit Acute Care Hospitals in 1994²⁹ that encouraged hospitals to provide benefits that enhance the health status of designated communities and aim to reduce racial and ethnic disparities in health status. The A.G.'s Community Benefits Guidelines for Health Maintenance Organizations, issued in 1996,³⁰ encourage a commitment to reducing cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.

The development of integrated networks and mergers was fueled by the need to provide a comprehensive continuum of care. The emergence of megaproviders enabled different entities to combine their expertise and like entities to capture greater market share. However, we are currently seeing its failure as the different cultures within these merged entities could not be melded. At the same time, the growing dominance of megaproviders are beginning to threaten the viability of small community-based organizations that have historically targeted ethnic-specific communities. Providers who disproportionately serve and maintain ties to ethnic minority communities could disappear. As megaproviders begin to drive the standard for health care delivery, the demise of ethnic-specific agencies and community-based organizations could be replaced by mainstream comprehensive systems.

Cultural competence has very different meaning for organizations whose missions are dedicated to serving culturally specific populations (i.e., ethnic-specific agencies or community-based organizations (CBOs))

vs. institutions whose missions are dedicated to serving all populations (i.e., mainstream agencies). A CBO responsive to all populations would dilute its very mission while cultural competence is core to its mission and programs. The goal of CBOs is not to be more diverse, but to fill an unmet need and advocate for the larger system to become more responsive to its targeted population. Within large mainstream institutions, cultural competence often means diversity initiatives to ensure that the institution is responsive to racial/ethnic populations. While the demand for all systems to become culturally competent is critical, the role of and criteria for community-based organizations must be different from those within the mainstream.

SERVICE DELIVERY ISSUES: COSTLY VS. COST EFFECTIVE

Most initiatives on cultural competence focus on the service delivery systems, and the skills or attitudes of providers within that system. Essentially, *Who delivers the care?* As the demand for institutions to be culturally competent has grown, the number of workshops, conferences, and training to promote the diversity, awareness, and skills of providers serving a diverse population has mushroomed. Many institutions now have cultural competence initiatives or designated offices to address specific needs of ethnic minority populations. It is common for organizations to articulate a commitment to diversity, multiculturalism or cultural competence in their goals, objectives, or mission statements.

Few initiatives focus on a second, and perhaps more important question: *What is the system of care, and is it culturally competent?* An examination of the governance, administrative and consumer levels is as important as examining provider competencies. To ensure that the system is culturally competent, systemic variables to evaluate these levels for all segments of the population include: *Do all segments of the population have equal access to care? What are the utilization patterns for different racial/ethnic groups? Is quality of care provided as measured by health status of the designated population groups?*

Access to Care

Access to care, or the degree to which services are convenient, quickly and readily obtainable, is a core cri-

terion. This has been a primary focus of cultural competence activities, typically described as cultural and linguistic barriers to care. *Can diverse segments of the population access care?* For non-English speaking populations, the paucity of bilingual providers has necessitated interpreters as intermediaries in the provider-patient dyad. While few have argued the importance of being able to communicate with the patient in his/her primary language, controversy has occurred over its implementation and cost. Bilingual providers are generally more available within ethnic-specific agencies and community-based organizations. This is complemented by interpreters, often hired as nursing assistants, case managers, or outreach workers to perform other patient-related functions. Within hospitals, interpreter pools for different languages are often used and triaged to where they are needed. AT&T interpreters are commonly used for back-up or for more esoteric dialects and languages; this has been criticized because it is not face-to-face, and is often provided by untrained interpreters or ones who are unfamiliar with medical terminology. The use of interpreters, in general, has been criticized because of long waits, inappropriate translations, and inconvenience in scheduling appointments. Its absence altogether or the use of family members, especially young children, as interpreters has been severely criticized.

While generally considered necessary to ensure access to care, the cost of interpreters is not factored into reimbursement mechanisms. Differential reimbursement or incentives is also not factored in for bilingual providers. Some agencies and institutions include differential pay scales for bilingual providers as a recruitment incentive. While this is a positive practice, it has inadvertently resulted in their competition with ethnic-specific agencies who are unable to match these pay differentials when the majority of their staff are bilingual, and there is no differential in reimbursement.

Cultural barriers, while recognized as important to cultural competence, are often given little attention in the implementation of programs and policies. Institutions have attempted to provide not only translated materials, but also materials that are culturally relevant and appropriate in their marketing and outreach efforts. Institutions have also provided in-service training to promote cultural awareness or build cultural knowledge of racial/ethnic groups that they serve, often described as diversity, multicultural, or cultural competence initiatives.

Utilization

Utilization refers to which services are being used, their availability in a system, how frequently, and whether their use is appropriate. *What are the utilization patterns across diverse segments of the population?* Enabling services supporting the medical visit have typically been found to be necessary to promote appropriate utilization when working with low income and ethnic minority populations. Enabling services, which include case management, outreach, transportation, babysitting, and those services enabling clients to use the system, also have been omitted from most reimbursement mechanisms; if provided, they are expected to be covered by grants. California and Hawaii include an adjustment in their capitation rates of approximately \$1.50 to cover the cost of these services.

Utilization patterns have been shown to differ by population variables. Low income, immigrants/refugees from ethnic/minority groups typically delay entry into care, underutilize services, and/or overutilize emergency room services because of language, cultural, and financial barriers. While many ethnic-specific agencies have organized their program services to promote appropriate utilization, cost benefit analyses of these strategies have not been conducted. The use of ethnic identifiers would help to promote this process.

Quality of Care

Quality refers to the question, *How good is the care once it is received?* While earlier emphasis in cultural competence has focused on access and utilization issues, there is now an increasing focus on culturally competent principles of quality and outcomes. Some principles of quality include:

- Access to culturally competent services
- Linguistically appropriate and culturally relevant services at all points of client contact
- Biculturalism and multiculturalism as a model for assessment and intervention
- Clinical outcomes which promote improved health status of the targeted communities

Principles of diversity³¹ and cultural competence³² increasingly are being articulated as important to a quality health care system. Community health psychology integrating biopsychosocial factors and emphasizing a community-based approach to health care delivery has also been proposed as a model.³³ However, these prin-

ciples have not been translated into measurable outcomes, professional standards, or competencies that have been institutionalized within the mainstream health care delivery system. Often, the existence of an institutional diversity initiative is used as the sole criterion for defining its cultural competency. Moreover, the assessment of cultural competence is often limited to provider skills without looking of systemic issues within an institution or macroscopic issues of health professions training, professional and regulatory bodies who set the standards, and payers who determine the reimbursement rates. The collaboration and intersection of these multiple sectors are critical. Cultural competence is costly when instituted as an add-on initiative, but cost-effective when integrated into the multiple factors critical to providing quality health care.

Different sectors characterize the service delivery system. One example of an effort in the hospital sector is the Office of Community Benefits at the Beth Israel-Deaconess Medical Center, which contains a Cultural Competence Oversight Committee to look at its organizational environment, workforce, and patient care to evaluate and develop its cultural competence. It has published newsletters, supported environmental and protocol changes, and hosted multicultural events and conferences to develop the "business case for cultural competence." It also has worked with the Picker Institute to incorporate the patient's perspective to improve care through the inclusion of health beliefs, to understand and integrate cultural perspectives of patients into care and to value cultural differences. Measures, however, have yet to be developed.

Community health centers, on the other hand, see a disproportionate number of low income and ethnic minority clients. A handful of them are ethnic-specific agencies targeting racial/ethnic populations, and are committed to being responsive to the specific racial/ethnic groups they serve. Cultural competence is integral to the programs and missions of these agencies. Many of the community-based organizations are ethnic-specific agencies targeting Black, Latino, Asian or Native American communities. Most started as grassroots organizations and have strong social service, community outreach, or civic service components. The Latino Health Institute is one such agency targeting the Hispanic community, and combining prevention and community outreach activities with public health, and research activities. It offers training and consultation on cultural competence.

TRAINING ISSUES

An examination of health profession training is important to assess the cultural competence of the institutions training the providers who deliver the care. Currently, many are playing catch-up by providing workshops, training, and continuing education conferences for providers to develop their cultural competence. Often, this takes the form of cultural knowledge about specific populations and communities under the premise that one must know about the beliefs, values, practices, and lifestyles of a particular culture in order to work with members from that culture. Less frequent, but more important, is the presentation of multicultural principles and culturally competent frameworks to guide practice.

The Society of Teachers of Family Medicine (STFM) published curriculum guidelines for teaching culturally sensitive and competent health care to family medicine residents and other health professions students.³⁴ The Health of the Public Initiative was funded by the Pew and Rockefeller Foundations for medical school training, with programs locally at Tufts University School of Medicine, Department of Family Medicine and Community Health and at Cambridge Hospital. This initiative used a systemic approach to promote the health of communities and to reorient academic health centers toward community health needs.³⁵

Two approaches to health professions training relevant to cultural competence are important to mention. The Center for Community Health, Education, Research, and Service (CCHERS) and Center for Minority Training Program (CMTP) train health and mental health professionals targeting diverse populations, and have developed culturally competent approaches to address specific population needs. CCHERS is one example of a community-based perspective with a holistic vision of health professionals focused on proactive services to the communities in which they live and work. Its goals are to provide an "out-of-hospital educational system for professionals to deliver community focused, real world health care decisions, and to create academic/community partnerships." The other approach has been through an overarching initiative within a generic training program to be more culturally competent and responsive in serving diverse populations. Harvard Medical School and Beth Israel Deaconess Medical Center³⁶ are two such institutions that articulate a commitment to diversity and have "made the business case for cultural competence."

GUIDELINES AND STANDARDS

Cultural competence has increasingly captured the imagination of those in health and human services. The public sector, service delivery system, training institutions, regulatory authorities, and payers all have begun to include concepts of diversity and cultural competence in their mission statements and to develop diversity, multicultural, and/or cultural competence initiatives. While guidelines and standards have always guided the professions in the definition of quality, there is a growing emphasis on quality indicators and outcomes that are less aspirational and more measurable.

Professional Standards

What are the standards or guidelines to define culturally competent quality? To date, cultural competence has been defined as aspirational principles or guidelines. Access to care (i.e., *Can they get in?*), Utilization patterns (i.e., *Do they use it?*), and Quality of care (i.e., *How good is it?*) for cultural competence have not been translated into quality indicators or outcomes that are monitored, evaluated, or mandated as professional and regulatory standards.

The Office for Ethnic Minority Affairs of the American Psychological Association issued Guidelines for Providers of Psychological Services to Linguistic/Ethnic Minority populations in 1990 to provide a sociocultural framework for psychologists to consider diverse values, interactional styles, and cultural expectations in a systematic fashion.³⁷ Massachusetts was the first, and one of few states, to mandate program and professional experience requirements related to racial/ethnic basis of behavior for the licensure of psychologists in 1993, i.e., cultural competence became a proficiency necessary for professional licensure. This has yet to be expanded to other professions. Research evaluation guidelines,³⁸ program guidelines, and ethical guidelines for providers all have been developed to articulate aspirational principles to define these competencies. The California Department of Mental Health, mentioned above, established a Cultural Competence Task Force in 1993, and has since established standards and plan requirements for Mental Health Plans to achieve cultural and linguistic competency.³⁹ This translated into a legislative mandate requiring all counties to submit a cultural competency plan to include the population, organizational and service provider assessments and services designed to address cultural competence.⁴⁰ These plans are to include:

demographics, policies, practices, human resource composition, quality of care criteria, and assurance to ensure cultural competence with specific measures and indicators. Within these standards and a series of criteria, there must be observable changes in behaviors, skill attainment and attitudes in order for a therapist to be judged competent to work with cultural others,⁴¹ i.e., multicultural proficiency.

The Health Care Financing Administration (HCFA) issued a draft regulation in September 1998 to require that state agencies ensure that managed care organizations provide services in a culturally competent manner since more than one-half of Medicaid recipients are members of racial or ethnic minority groups.⁴² These regulations require managed care organizations (MCOs) to propose a method for determining the prevalent languages spoken by their members. Resources for Cross Cultural Health Care is working on a U.S. Department of Health and Human Services (HHS)-sponsored project to develop national standards for culturally and linguistically appropriate services (CLAS) in health care, and to develop a research agenda on CLAS issues (see Appendix A). They are currently written as provider requirements, but ultimately will be written for use by policymakers and advocates, and could be used to evaluate documents such as the recently released Medicaid MCO regulations.⁴³ This evaluation project will review existing language and cultural competence standards or measures in a national context assess the information or research needed to relate these guidelines to outcomes, and develop a draft national standard and an agenda for future work.

Outcomes

We now see trends in health care toward an increased emphasis on quality indicators and measurable outcomes. Whereas the development of professional standards has implications for licensure and accreditation, the measurement of outcomes has implications for reimbursement and accountability. The identification of quality indicators provides the clinical and program criteria against which to measure these outcomes. The Bureau of Primary Health Care⁴⁴ identified seven such indicators to assess the important aspects of culture and develop cultural competence programs, but these have not had the force of standards to regulate the delivery of health care services. Identification of indicators has largely been limited to language access, or the availability of interpreters. In Massachusetts, the statewide medical interpreter association has

developed interpreter standards and provides continuing education workshops to maintain and improve skills.⁴⁵

On the federal level, the Disadvantaged Minority Health Act of 1990 (P. L. 101-527) provided a legislative directive for language access. While this was limited because it was funded by only \$3 million for the entire country, it spawned the proliferation of related initiatives. The Center for Linguistic and Cultural Competence in Health Care was established in 1995 by the U.S. Office of Minority Health to address the health needs of limited English speaking populations. The Office for Civil Rights of the U.S. Department of Health and Human Services defined inadequate interpretation as a form of discrimination under the Civil Rights Act of 1964. Thus, cultural competence became defined as a civil rights issue.

Cultural competence guidelines for managed behavioral health services provided to racial/ethnic populations, completed in 1998, were developed by four national panels commissioned through the Center for Mental Health Services (CMHS) in conjunction with the Western Interstate Commission for Higher Education (WICHE).⁴⁶ These guidelines identified indicators and domains with an underlying principle that, in the provision of mental health services, consumers and their experiences should be viewed within the context of their cultural group.

Not only are organizations and providers being asked to be culturally competent as an ethical standard or aspirational goal, but also they are asked to identify measurable outcomes and specific quality indicators. *How does an organization get there? How do you know if you are there? What are the key components and obstacles to achieving cultural competence?* And last, but not least, *How do we measure it?* This emphasis on outcomes has bearing on influencing scope of practice, and achieving a set of professional standards that mandates cultural competence as essential for licensure, accreditation, and risk management. None of those developed so far has been tied to population health status.

Quality Indicators and Assessment Tools

Cultural competence initiatives in several states have resulted in the development of assessment tools to measure outcomes, e.g., WICHE in Colorado,⁴⁷ Mason in Portland, Oregon,⁴⁸ Latino Coalition for a Healthy California, and New Jersey.⁴⁹ These assessment tools are mostly process and survey tools, and include patient

satisfaction surveys, provider self-assessment questionnaires, and organizational self-assessment checklists of cultural competence variables.

These differ from the use of report cards that operationalize, measure and monitor quality indicators to hold health care providers and payers accountable; report cards are slowly being considered as a tool to assess cultural competence. The National Association of State Mental Health Program Directors (NASMHPD) worked on a core set of quality indicators that public purchasers (states) could use when negotiating contracts with private providers particularly through managed care risk contracts. Four primary domains: access, accountability, outcome, and plan management were identified. Indicators for each domain and measures for each indicator were developed. The CMHS used these domains and indicators to develop a report card for cultural competence modeled after the Mental Health Statistics Improvement Program (MHSIP), a consumer-oriented mental health report card.⁵⁰ The report card, for use by states to monitor standards of cultural competence, has yet to be implemented. The Health Services Research Institute has compiled a directory of existing measures, standards, and datasets for cultural competence in behavioral health.

Currently, both the Joint Commission on Accreditation of Health Care Organizations (JCAHO), which regulates hospitals, and the National Committee on Quality Assurance (NCQA), which developed the Health Plan Employer Data and Information Set (HEDIS) measures to evaluate health plan performance, have quality indicators related to cultural competence limited to language access. These measure the number of bilingual/multilingual providers and staff available; they have not addressed the complexities of language access or cultural appropriateness.

The Agency for Health Care Policy and Research (AHCPR) developed the Healthcare Cost and Utilization Project Quality Indicators (HCUP QIs), a set of 33 clinical performance measures that informs hospitals' self-assessments of inpatient quality of care as well as state and community assessments of access to primary care. Three primary dimensions include: adverse hospital outcomes, inappropriate utilization of hospital procedure, and avoidable hospital admissions. The ability of this instrument to define and track outcomes of interest to populations at risk can be used to include dimensions of cultural competence, and differential rates among racial/ethnic groups.

Assessment tools to measure these indicators have also been developed. CONQUEST, the Computerized Needs-Oriented Quality Measurement Evaluation System, is a quality improvement software tool, also developed by the AHCPR, comprised of clinical performance measures measuring quality through provider characteristics (e.g., whether appropriate action was provided at the right time) and procedures which result in better outcomes for the patient. Other assessment tools have focused on costs and medical expenditures, or utilization patterns. The Medical Expenditure Panel Survey (MEPS) is a nationally representative subsample of the National Health Inventory Survey (NHIS) conducted by the National Center for Health Statistics (NCHS). Data are collected over multiple years, using a computer-assisted interviewing system and includes demographics, health status, and health insurance data related to expenditures. While none of these tools was developed for measuring cultural competence quality, MEPS does disaggregate use and expenditure by racial/ethnic groups, and can potentially identify racial/ethnic variations in utilization patterns.

The development of quality improvement projects or plans by states and trade associations has been another way to influence professional standards and guidelines. The incorporation of outcomes associated with population health status can be used to monitor and ensure cultural competence as an aspect of clinical and program quality.

The Health Care Financing Agency (HCFA) contracted with Abt Associates to develop recommendations of measures to support the requirements of Quality Improvement System for Managed Care (QISMC) relating to cultural competence. QISMC is a set of standards and guidelines designed to ensure that managed care organizations provide health care services to Medicare and/or Medicaid beneficiaries in ways that "protect and improve the health and satisfaction" of their enrollees; it is an ongoing process of performance assessment and improvement.⁵¹ Essential elements include:

- Availability: needs assessments to understand community needs and ethnic makeup
- Outreach: strategies tailored to communities based on needs assessments
- Access: reaching patients from diverse cultures, meeting language needs, breaking down geographic barriers

- Cultural Competence: in diagnosis, treatment regimens, patient compliance and satisfaction, and clinical outcomes.

PAYER ISSUES: MANAGED CARE

While cultural competence initiatives often followed a separate track from the cost containment efforts of managed care, we cannot evaluate cultural competence without looking at the reimbursement structure, i.e., *Who pays for care?* As the service delivery system has shifted toward a managed care model, there has been a growing concern that cost containment issues will preempt the demand for cultural competence as important, but too expensive.

Public payers have embraced cultural competence given the disproportionate share of racial/ethnic groups in Medicaid and Medicare programs. HCFA set standards for culturally and linguistically appropriate services, and the Massachusetts Department of Medical Assistance has a cultural competence initiative to ensure that MCOs are responsive to diverse racial/ethnic groups. The Massachusetts Behavioral Health Partnership (MBHP) also has a cultural competence initiative, in which behavioral health agencies are invited to submit cultural competency plans; these plans must include an agency self-assessment and community assessment process.⁵² This initiative promotes cultural competence of providers within the MCO network only; an examination of how MCOs are culturally competent is also needed. Harvard Pilgrim Health Care has a Cultural Diversity Office that chronicles its efforts on an annual basis with its *Diversity Journal*. As a MCO, it offers ongoing diversity workshops to Harvard Vanguard and the rest of its provider network to promote systems awareness and provider training, and has diversity goals linked to its executive compensation. Some issues yet to be reviewed among MCOs include:

- What *benefits* are covered in the plan? Are they specific and relevant to diverse populations? Is alternative medicine covered given its common usage by ethnic minorities or is it not considered medically necessary?
- What about *access*? Does the gatekeeper function, a keystone of managed care, prevent access to care for those most in need?
- Who is *eligible*? How does one become enrolled in the plan? Is there adverse selection against

ethnic minority populations because they are high risk?

- What about the *provider network*? Does limiting the number of providers in a panel result in limiting access and choice to bilingual/bicultural providers? How are providers evaluated as to their level of cultural competence?
- How is *patient satisfaction measured*? Are surveys conducted only in English?
- Given the tendency among ethnic minority groups to underutilize services, what *outreach efforts* are there to promote access, availability and utilization by these groups?
- As MCOs develop criteria and guidelines to manage the provider network, what *consumer protections* and criteria are there to ensure that they do not inadvertently pose barriers for different racial/ethnic groups?

Whereas racial/ethnic groups are more likely to have poor outcomes, consumer protections are needed to ensure that profiling and risk adjustment ratings are not used by MCOs to impact adversely ethnic minority populations. Given racial/ethnic differences in world views, utilization reviewers may deny authorization for services based on set criteria because of a failure to understand the cultural issues involved. While MCOs are increasingly emphasizing a consumer-oriented approach, quality indicators and consumer satisfaction ratings are often dichotomous from cultural competent measures, which are deemed secondary in importance or too costly to consider. For example, member satisfaction surveys are generally conducted only in English. Quality measures are not specific to diverse populations. Ethnic identifiers of the provider network are not available to allow consumer choice. Measures of cultural competence are absent, other than provider self-report of language availability, i.e., unlike the extensive credentialing process required of providers in the network. There are no increased rates for bilingual providers. Reimbursement for interpretation is considered a cost to be borne by the provider.

The development of provider networks and megaproviders occurred to gain a competitive edge in managed care contracting. While these networks were developed to provide a continuum and comprehensive array of services, ethnic-specific services and responsiveness to a diverse population within these networks are often diluted by the few providers available to serve the entire network, i.e., while the network is representa-

tive of the population, services are not targeted to meet their needs. Contracting by MCOs that favor these networks often adversely selects against small community-based providers.

POLICY ISSUES: MANDATING CULTURAL COMPETENCE?

The health care trends, service delivery, training of providers, reimbursement, and the development of standards already discussed all have policy implications for cultural competence. *Should cultural competence be mandated? Should we define standards and outcomes for providers and payers to ensure a quality health care system responsive to all segments of the population? What are the obstacles to achieving cultural competence within the health care system? What are the cost implications?* Policymakers, decision makers, and legislators should consider the following policy issues:

Mandating the Use of Ethnic Identifiers

An underlying notion of a culturally competent system of care is that it is responsive to the lowest common denominator of the diverse groups within the total population. To achieve cultural competence within the entire health care system, we need to start from a premise that all segments of the population have equal access to quality care. To do this, we need to examine the population demographics, i.e., who makes up the population, who is or is not served? The ability to identify the ethnicity of its members is critical to its implementation.

This is often viewed as too costly or unwieldy, although the federal 2000 Census has already begun this process by expanding the number of racial categories and allowing individuals to check more than one racial/ethnic category. State health agencies in Massachusetts could require that all public datasets be similarly expanded and that MCOs collect and track ethnic-specific data using federal census categories. This will enable the identification of racial/ethnic differences in utilization, access, and quality, and the identification of provider expertise. Whereas there has been a history of discriminatory actions associated with ethnic identification, consumer protections are essential to avoid any adverse impact of identifying ethnicity. For example, the use of ethnic identifiers could also be

used for profiling high risk and frequent users for adverse risk selection.

Population-based vs. Geographic Criteria

The growth of megaproviders and the development of regional networks have consistently defined access to care based on geographic boundaries rather than on community- and population-based criteria. Their size and dominance in the health care marketplace, therefore, drive the indicators and measures being used to define health care quality. The geographic focus in parceling out covered lives in managed care systems and in identifying vendors to purchase services defies the crosscutting issues of a population focus. When defined from a geographic focus, specific ethnic populations become more costly to serve and cultural competence become an add-on cost. The identification of ethnic communities often cuts across geographic boundaries.

The use of population based criteria for payers and state agencies in defining regions, in addition to geographic boundaries, would permit greater integration within the health care system, and be more responsive to the diverse needs of communities. Individuals from racial/ethnic groups often live in one geographic area, but identify with communities with large concentrations in another. Regional boundaries used in the public and private sectors, by providers and payers, often serve to mask the identification of populations and communities which define themselves across geographic boundaries, or do not make a large enough impact within any particular defined boundary.

Language vs. Culture

The availability and use of interpreters is a basic and necessary criterion for a culturally competent system; however, it is not sufficient despite the fact that it is often viewed as the sole criterion for cultural competence. Most initiatives on cultural competence emphasize linguistic access and the availability of interpreters for non-English speaking groups. Consumers who prefer to choose ethnic-specific providers often cannot get institutions to identify this cultural expertise within their provider networks, or even to view cultural competence as an expertise or proficiency. Definitions of cultural competence must go beyond interpreter support to the use of bilingual providers and the integration of cultural appropriate care.

Eliminating Disparities in Health Status

Risk factors have been a common approach used to examine health status, resource allocation, and program development in the public and research sectors. Many in minority communities have objected to this approach because it has often had adverse consequences for ethnic minority populations with the tendency to marginalize the very groups that are defined. Many support the use of a resiliency approach or the identification of protective factors as an alternative to validate and promote those elements that are positive and facilitate survival and adaptation within a racial/ethnic group.

The longstanding disparities in health status among racial/ethnic groups do need to be addressed, and are consistent with President Clinton's initiative to Eliminate Disparities by 2010.⁵³ As mentioned above, the Massachusetts Department of Public Health's Minority Health Advisory Board assists the Department in achieving its goals to eliminate disparities.

At the same time, the notion of racial disparities uses a comparative paradigm in which Whites become the comparative standard. This often does not identify meaningful trends among racial/ethnic groups with small sizes because their differences are masked or insignificant in representative samples. These comparisons also tend to ignore meaningful indicators within racial/ethnic groups that are not significant within the White population. Oversampling can be used to get meaningful sample sizes for small ethnic groups. Use of intraethnic data as comparison groups, i.e., not requiring White comparison groups, should be considered a valid research paradigm. More importantly, these strategies presume that we support an underlying principle that the health care needs of all groups within the population must be met to achieve cultural competence.

Standards: Flexibility vs. Uniformity

It is common to expect adherence to a uniform set of professional or practice standards. Emphasis on diversity and cultural competence challenges us to implement standards that are flexible enough to capture the differences within diverse populations without compromising quality. A one-size-fits-all mentality in applying eligibility criteria, credentialing standards, practice standards, etc. merely overlooks and omits variables essential to achieving cultural competence. The credentialing and licensure of providers should require cultural competence as a proficiency.

Culture and language are still viewed as distractions or incidental to health care delivery. Existing standards tend to emphasize individuals, not individuals in the context of families and communities, i.e., to promote the *health of communities*. Standards must include *system competencies* such as: workforce diversity, language capacity at all points of entry into care, population based criteria of health status, enabling services to promote access to care for underserved groups, and culturally relevant outcomes to measure client success.⁵⁴ Institutions should be required to meet a set of culturally competent quality standards. Existing standards can be reviewed to assess whether or not they meet culturally competent criteria.

Outcomes as Measured by Health Status

The growing movement toward accountability and outcomes in the health care system must dovetail with a similar emphasis in the area of cultural competence. This should include the identification of clinical outcomes, which are population based and culturally relevant. It should include system audit tools, consumer report cards, accreditation standards, and HEDIS measures that measure specific components of cultural competence and target improved health status as an objective.

As we move toward an outcomes-oriented approach, we need to ask: How do we measure it? Two approaches are important. Cultural and systems audits or report cards can be used to assess the degree to which institutions, providers, payers, and systems are culturally competent. These can include both self-assessment surveys as well as independent audits. On the other hand, existing tools measuring quality, utilization or medical expenditures can be adapted to incorporate criteria for cultural competence.

Voluntary guidelines modeled after the Massachusetts Attorney General's Community Benefits Program is another mechanism to define expected outcomes as measured by the health of the designated community or population. Modifying and implementing the standards developed by the CMHS would provide a useful set of criteria and indicators for cultural competence. Development of monitoring and oversight mechanisms would be important to ensure compliance.

Mandating Cultural Competence

Should we mandate cultural competence? Such a mandate could ensure oversight, compliance and resource allocation to achieve its implementation. Undoubtedly, issues are raised by such a mandate; for example: *What should be the minimum criteria? Who should require it? How do we set criteria for training, research, and service?*

Massachusetts could follow what has been done in California using a 3% threshold criterion. Counties must provide linguistic and culturally appropriate services if 3%, or at least 2500 individuals, of the population within the county speak a language other than English. Massachusetts could define a threshold criterion for racial/ethnic groups within a pre-defined area of measurement (e.g., zip code) to ensure that services targeting that group will be available and culturally competent. Given that racial/ethnic groups tend to cluster in geographic areas, a variation might be to let communities define their own target areas.

Currently, many initiatives are limited to the inclusion of cultural competence in mission statements, objectives, or plans. These need to be expanded such that self-assessment tools,⁵⁵ continuous quality improvement plans, and continuing education training include the planning, development, and implementation of cultural competence plans and transformation within an integrated system of care.⁵⁶ Federal, state, local, and private entities could expand and broaden their objectives to define how they operationalize cultural competence through resource allocation, program development, quality indicators, and regulatory oversight. Allocation of resources must be woven into and integrated in the fabric of the care delivery system.

Where Do We Go From Here?

Many institutions have articulated a commitment to diversity, have cultural competence initiatives, or have offices designated to address specific needs of ethnic minority populations. Cultural competence is core to the mission and programs of most community-based organizations. The concerns of multiple stakeholders impinge upon the system of care. To achieve cultural competence within a system of care, *collaboration across multiple sectors* is needed. The multiple sectors within the health care system include: hospitals and tertiary care system, community health centers and community-based organizations, payers, training institutions, research and outcomes, state agencies and

regulatory authorities, trade associations, legislative and advocacy groups. We can model after best practices and learn from past initiatives.

What Can We Do?

Integration of systems across these multiple sectors is needed to identify objectives and define outcomes which includes cultural competence as a defining criterion. While awareness of culture and the importance of a culturally competent system has grown significantly over the past decades, there is still much to be done. Mission statements, goals and objectives need to be translated into action plans. Programs and services, and more importantly, the system of care including payers and regulatory authorities need to be evaluated and audited for their cultural competence. Outcomes and outcome measures for cultural competence need development, implementation and oversight to ensure compliance throughout the system and its multiple sectors. *What can each of these sectors do?*

Providers

The provider community can institute agency staff training, prevention, community health education activities and agency and self-assessment audits which examine, identify, and promote cultural competence in the delivery of care. These can include cultural competence as objectives in their strategic plans, and develop administrative and clinical quality performance measures to achieve them.

Trade Associations

Trade associations can support clinical practices, organizational systems, licensure, credentialing, and professional standards that require training and proficiency in cultural competence not only for their members, but also within the association.

Public Sector

State and local agencies can ensure that community-based vendors will be eligible and competitive for dollars that are outsourced. They can provide regulatory oversight which mandate culturally competent quality indicators. They, too, can do self-assessment and system audits to examine, identify, and promote cultural competence in their activities. It is important that they identify and bring to the table, racial/ethnic professionals with expertise in cultural competence to review and

provide input into oversight, regulatory, and other activities related to health of communities.

Payers

Payers can respond to health of the community objectives, and use a population based approach in the definition of benefits and protocols. Design of benefit packages, utilization management activities, credentialing, and quality assurance must be relevant to ethnic-specific populations, and support small ethnic-specific, or community-based providers. Risk factor rating adjustments and population based profiling should have as its goal, the reduction of disparities, not adverse selection or the reduction of costs.

Regulators

Regulatory authorities, training and accrediting institutions can provide guidelines and standards to ensure that training of providers and oversight of providers and institution are culturally competent. This may include the review of licensure, credentialing criteria, HEDIS measures, and accreditation site visitors. They can ensure that racial/ethnic professionals with expertise in these areas are included in the process.

Legislators / Policymakers

Legislators and policymakers can create a legislative or regulatory mandate to require the achievement of cultural competent indicators. Cultural and linguistic competence standards using a 3% threshold criterion can require the provision of culturally competent services if 3% of a particular racial/ethnic group resides within the defined geographic area. Legislators can also consider the recommendations of state initiatives, as they are developed.

Consumers

Patients and their families, or consumers, can insist on cultural competence in the measurement of patient satisfaction. The use of report cards is a means by which to hold institutions and providers accountable. Consumers can define their own cultural and linguistic needs and the ways in which the system can be responsive to them.

Conclusions

In conclusion, this is a New Age of economic imperatives. As we enter the 21st century, the health care system is evolving toward an integrated system of combined hospital and community systems, health and mental health, Western and traditional medicine, primary and tertiary, technology and clinical practice, etc. As providers and systems strive to gain market share, competition for patients and covered lives becomes foremost. Regional systems, alliances, mergers, and networks have become commonplace with megaproviders dominating the marketplace and defining the health care system.

Whereas the emergence and advocacy for cultural competence within health grew from the ranks of community-based systems targeting ethnic-specific populations, it is essential that these systems do not become defunct as the health care system evolves. To achieve cultural competence within a system of care, *collaboration across multiple sectors* is needed. While awareness of culture and the imperative of cultural competence has grown significantly over the past decades, there is still much to be done. Mission statements, goals and objectives need to be translated into action plans. Programs and services, and all aspects of the system of care including payers and regulatory authorities need to be evaluated and audited as to their level of cultural competence. Standards of culturally competent care need to be mandated, developed, implemented and monitored throughout the system and across its multiple sectors. As we have shifted from cultural sensitivity to cultural competence, we now must shift to the development of standards and measurement of outcomes for cultural competence.

Appendix A*

Draft Standards for Culturally and Linguistically Appropriate Services (CLAS) Version 1: July 1998, Revised with Advisory Committee input: September 1998

1. Health care providers have a responsibility to offer culturally and linguistically appropriate services (CLAS) to ensure accessible and quality health care for diverse populations.
2. Providers should make available for all limited English proficient (LEP) individuals oral bilingual/interpretation services.
3. Providers should provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
4. Providers and other agencies that communicate with LEP about health related matters should translate and make available commonly-used written materials and signage for members of the predominate language groups in their service areas.
5. Providers and policymakers should support the development and adoption of national standards for health care interpreting, training, and skills assessment. In the meantime, providers should be required to ensure that interpreters and bilingual staff can demonstrate: bilingual proficiency, training that includes the skills and ethics of interpreting, and fundamental knowledge in both languages of any specialized terms and concepts peculiar to the program or activity. The skills and fluency of interpreters should be evaluated on an ongoing basis.
6. Providers should have an organized management strategy to address culturally and linguistically appropriate services (CLAS), including plans, policies, procedures, and responsible individuals.
7. Providers should have formal mechanisms for community and consumer input/involvement at all levels of service delivery, including planning, operations, evaluation, training, and, as appropriate, treatment planning.
8. Providers should require and, as appropriate, offer ongoing education and training of administrative, clinical, and support staff in cultural competent service delivery.
9. Providers should recruit, retain and promote a diverse and culturally competent administrative, clinical, and support staff.
10. Providers should develop (or integrate into existing mechanisms) institutional policies and procedures to address complaints by patients and staff about unfair, culturally insensitive or discriminatory treatment.
11. Providers should collect information about clients' primary (at-home) language use and include this information in any patient records used by provider departments.
12. Providers should use a variety of methods to collect and utilize demographic, cultural and epidemiological data about communities in the provider's service area, and on the ethnic/cultural needs of its own patients.
13. Providers should implement ongoing organizational self-assessments of cultural competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS in other organizational internal audits.

*Diversity Rx is sponsored by: The National Conference of State Legislatures, Resources for Cross Cultural Health Care, The Henry J. Kaiser Family Foundation.
URL: <http://www.diversityrx.org>

Appendix B*

Systems Checklist of Cultural Competence Questions

CULTURALLY COMPETENT CARE

- Is staff adequately trained to work with diverse populations of the community served?
- Do patients have the choice to see a provider from their own culture?
- Do beneficiaries from minority populations receive more critical and relevant interventions reflecting disparities?
- Do they express satisfaction with their care? Are surveys reaching out and representing non-English populations?
- Are community outreach and education programs focused on disparities prevalent within diverse populations?
- Are there guidelines for medical interpreting available?
- Are there financial provisions to support institutionalizing cultural competence throughout the organization?

CULTURALLY COMPETENT ACCESS TO CARE

- Does the agency welcome and outreach to racial/ethnic groups in their target area?
- Is there diversity and representation of minority professionals and managers within the system?

CULTURALLY COMPETENT QUALITY MEASURES

- What quality measures are there to measure cultural competence at all points of the system?
- What are the utilization patterns, enrollment rates, and health status indicators for diverse groups?
- Do patient satisfaction measures reflect differences within the population?

ACCESS

- Do all groups have equal access to services offered by the system?

QUALITY

- Are there quality indicators specific to population based measures of health status?

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