

Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda (1999)

Recommendations for National Standards and a National Public Comment Process

Full Report and Commentary

Project Staff

Julia Puebla Fortier, Principal Investigator
Yoku Shaw Taylor, Senior Research Associate
Resources for Cross Cultural Health Care
8915 Sudbury Road, Silver Spring, MD 20901
301-588-6051 RCCHC@aol.com

Rena Convisser, Project Manager
Center for the Advancement of Health
2000 Florida Ave, NW, #210
Washington, DC 20009-1231
202-387-2829

Guadalupe Pacheco, Government Project Officer
U.S. Department of Health and Human Services
Office of Minority Health
Rockwall II, 5515 Security Lane, #1000
Rockville, MD 20852
240-453-6174

*Produced for U.S. Department of Health and Human Service Office of Minority Health under contracts # 97T2261501D and #97T27190901D.
[1999]*

TABLE OF CONTENTS

[Acknowledgements](#)

[Recommended Standards For Culturally And Linguistically Appropriate Health Care Services](#)

Introduction

[Summary](#)

[Project Overview](#)

[Key Questions and Tasks](#)

[Summary of Findings](#)

[Implications for Policymakers, Providers, and Consumers](#)

[Conclusion](#)

Discussion of Methods

[Research Goal and Objectives](#)

[Research Questions](#)

[Sample Selection and Data Sources](#)

[Data Analysis Methods](#)

[Findings and Considerations in Recommending Standards](#)

[Initial Recommendations and Revisions](#)

Commentary On Standards

Bibliography

***Appendices**

1. [Source Documents List](#)

2. [Multicultural Health Best Practices Overview: selections](#)

Acknowledgements

Many people contributed generously to making this report possible, and we extend our appreciation to them:

Caren Ginsberg for her expert advice in designing the research methodology

Jane Perkins for her exceptional expertise on linguistic access to health care and the law, and especially for her time and attention during our visit to North Carolina

Jessica Kong for her patient administrative and logistical support

Rena Convissor and the staff at Center for the Advancement of Health for their cosponsorship of this project, and assistance hosting the advisory committee meeting

Guadalupe Pacheco and Valerie Welsh of the Department of Health and Human Services Office of Minority Health (OMH), for facilitating the grant for this work, and for their substantive intellectual and personal contributions

The individuals who participated in our advisory committee meeting or reviewed drafts of the report, for their pointed and challenging comments, and persistent engagement over many months of review and revisions:

Audrey L. Burwell, M.S.
Health Research Administrator
USDHHS National Center for Health Statistics

David Clark
USDHHS Centers for Medicare and Medicaid Services

Ethel Davis Chambers
New York State Office of Mental Health

Priscilla Coudoux
Community Health Connect Program Director
Northern Virginia Area Health Education Center

Shelby Dunster
Associate Director, Department of Standards
Joint Commission on Accreditation of Healthcare Organizations

Armando X. Estrada, MA
Department of Psychology
University of Texas

Leonard G. Epstein, M.S.W.
Senior Advisor on Cultural Competency Programs
Bureau of Primary Health Care
USDHHS Health Resources and Services Administration

Iris Garcia
Massachusetts Division of Medical Assistance

Marilyn Gellner, Program Manager,
Office of Diversity
Barbara Stern, Vice President
Harvard Pilgrim Health Care

M. Jean Gilbert, Ph.D.
Director, Cultural Competence
Kaiser Permanente California

Melba Hinojosa
California Department of Health Services

Robert C. Like, M.D., M.S.
Associate Professor and Director
Center for Healthy Families and Cultural Diversity
Department of Family Medicine
UMDNJ-Robert Wood Johnson Medical School

J. Ruben Lozano, Pharm.D.
Deputy Director, Program Compliance
California State Department of Mental Health

Cynthia Martin
Policy Manager
National Committee for Quality Assurance

Rose Martinez
Mathematica Policy Research

Leo Morales, M.D., Ph.D.
University of California at Los Angeles School of Medicine

Guadalupe Pacheco, M.S.W.
Public Health Advisor
USDHHS Office of Minority Health

Jane Perkins, J.D., M.P.H.
National Health Law Program

Alex Ross, M.S.
Senior Public Health Advisor
USDHHS Office of International Health

Miguel D. Tirado, Ph.D.,
Dean of Graduate Studies and Research
California State University-Monterey Bay

Valerie Welsh
USDHHS Office of Minority Health

Recommended Standards for Culturally and Linguistically Appropriate Health Care Services

Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these guidelines were developed with input from a national advisory committee of policymakers, providers, and researchers. In this report, each standard is accompanied by commentary that addresses its relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

Preamble:

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.
4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.
6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.
7. 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 interpreter services free of charge.
8. Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.
10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.
11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.
12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.
13. Develop structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.
14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

Introduction

Summary

This report recommends national standards for culturally and linguistically appropriate services (CLAS) in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these recommended standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

A separate report will discuss the information and research needed to relate these guidelines to outcomes, identify key research areas and questions, and propose a research agenda for future work in this area.

Project Overview

Context

Cultural diversity is a core part of the economic engine that drives the country, and its impact at this time has significant implications for health care delivery and policymaking throughout the United States. The world's 210 nations are well represented in the U.S. and these diverse cultures are continually being blended and merged. The draft U.S. Census for 2000 allows for 66 different categories of racial and ethnic combinations. In addition, mobility is such an ingrained feature of our society that diversity is likely to be an issue across America. Cultural diversity has clearly been expanding into all regions of the country—not just inner city and coastal areas, but throughout the Midwest, suburbs, and small towns of America.

Doctors offices, clinics, and hospitals see this diversity every day, and the need for culturally and linguistically competent health care services for diverse populations is attracting increased attention from health providers and those who judge their quality and efficiency. While certain providers have delivered appropriate services to diverse populations for many years, this has not been the case in many mainstream settings. As the mainstream begins to treat a more diverse clientele as a result of demographic changes and participation in insurance programs, interest in designing culturally and linguistically appropriate services that lead to improved outcomes, efficiency, and satisfaction has increased.

Cultural and linguistic competence suggests an ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter. For example, an elderly Bosnian woman being admitted with terminal cancer may present the following challenges for health care staff and organizations: she and her family do not read, speak or understand English; her Muslim faith requires modesty during physical examinations; and her family may have cultural reasons for not discussing end-of-life concerns or her impending death. A culturally and linguistically appropriate response would include interpreter staff; translated written materials; sensitive discussions about treatment consent and advance directive forms; clinical and support staff who know to ask about and negotiate cultural issues; appropriate food choices; and other measures. The provision of these kinds of services has the potential to improve patient outcomes and the efficiency and cost-effectiveness of health care delivery.

Unfortunately, many health care providers feel they don't have clear guidance on how to prepare for or respond to these situations. Up to this point, no comprehensive standards of cultural or linguistic competence in health care service delivery have been developed by any national body. Instead, Federal health agencies, state policymakers, and national organizations have each developed pieces of the puzzle. Some have developed definitions of cultural competence; others mandate providing language services to limited English speakers; others specify collection of language, race, and ethnicity data. Some approaches attempt to be comprehensive, others target a specific issue, geographic area, or subfield of health care, such as mental health. The result is a wide variation of ideas about what constitutes culturally appropriate health services, including significant differences with respect to the target population, scope, and quality of such services. Although limited in their jurisdiction, many excellent policies do exist, and the increasing numbers of model programs and practices prove that culturally competent health services are viable, beneficial, and important to consumers.

Purpose and Audience

As language about culturally and linguistically competent services proliferates in health policy discourse and practice, a common understanding of what this means is essential to assuring quality. Today, if a provider asserts they are culturally competent (which many increasingly do), it may be impossible for the consumer to know how that relates to services—if in fact it refers to specific services at all. Standards offer a guidepost for many different purposes and audiences. They set forth what should be done by service providers and how it should be done, and provide a basis for evaluation, comparison, and quality assurance by policymakers, consumers, and researchers.

To begin moving towards a national consensus on this issue, the U.S. Department of Health and Human Services Office of Minority Health (OMH) asked ***Resources for Cross Cultural Health Care*** to review and compare existing cultural and linguistic competence standards and measures in a national context, propose draft national standard language where appropriate, assess the information or research needed to relate these guidelines to outcomes, and develop an agenda for future work in this area.

While drafts of these standards have been circulated widely for comment, at this stage they are still recommendations and not mandates. Further review, revision, and support is desirable, and will likely be undertaken by OMH in the near future. Some of the standards, however, do reflect Federal obligations that most health providers are already responsible for upholding, and these will be noted in the commentary. What is unique about their presentation in this document is the level of detail given to issues of implementation and oversight.

As such, this document presents these proposed standards as guidelines for:

Providers, to understand and implement services that are accessible to and appropriate for diverse populations. This audience would include the clinicians, staff, managers, and trustees of health care organizations, systems and plans.

Policymakers, to draft consistent and comprehensive laws, regulations and contract language. This audience would include Federal, state and local legislators, administrative and oversight staff, and program managers.

Accreditation and credentialing agencies, to assess and compare providers who say they provide culturally competent services, and to assure quality for diverse populations. This audience would include the Joint Commission on Accreditation of Healthcare Organizations, the National Committee on Quality Assurance, professional organizations such as the American Medical and Nurses associations, and quality review organizations such as Peer Review Organizations.

Purchasers, to advocate for the needs of ethnic consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.

Patients, to be able to understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them.

Advocates, to promote quality health care for diverse populations, and to assess and monitor care being delivered by providers. The potential audience is quite wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant and other community-focused organizations; and local and national nonprofit organizations that address health care issues.

Educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of cultural and language on health care delivery. This audience would include health care professions educators and training institutions, as well as legal and social services professions educators.

The health care community in general, to debate and assess their applicability and adoption into standard health care practice.

Research Questions and Tasks

The initial intent of the project was to examine the nature and extent of measurement activities for cultural competence and to identify linkages between measurement and health impacts and outcomes. The first step of this project was to collect, review, and analyze measures or standards on cultural and linguistic competence currently in use. The body of work evaluated included selections from the following categories of literature:

Category 1. Extant documents related to linguistic and cultural competence policy and organization documents that describes a standard of practice or performance measure (e.g., internal institutional guidelines, regulations, state and federal laws, proposed certification standards, accrediting guidelines)

Category 2. Linguistic and cultural competence assessment tools

Category 3. Current and ongoing research on links between culturally and linguistically competent health services and outcomes/delivery efficiencies

After examining the literature for each of these categories, it was clear that the concept of cultural competence and its component parts had to be more carefully defined and described before exploring the measurement and outcome linkage issues. A decision was made to divide the project into two parts:

1. An analysis of documents that would lead to a description of cultural competence activities through the articulation of draft standards, and
2. The development of a research agenda on the relationship between culturally competent health services and health outcomes.

A sample of 30 documents in Category 1 was selected for closer review for part one of the project. After examining several reviews of assessment tools conducted by others (Klein; Roizner) we decided against further close analysis of the assessment tools, and instead chose to use the cultural and linguistic competence domains identified by those reviews to validate the elements to be examined by our project. The documents in Category 3 provide the basis for part two of the project, which will be available in a separate report. It will discuss issues related to developing a research agenda, and contain a matrix of research areas and key questions linked to the standards articulated in this report.

This project did not attempt to create an ultimate definition of cultural competence, given the many excellent definitions in the literature. As a working definition, we adapted one cited by the Office of Women and Minority Health at the Bureau of Primary Health Care, HRSA as follows:

"Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities."

As we reviewed the literature, we examined the source documents for provisions related to racial, ethnic, linguistic, cultural or religious issues in health care delivery. This scope is primary but not all-

encompassing of the issues surrounding culturally and linguistically competent health care services, and other researchers may feel that additional criteria should be considered (e.g., economic status, disability, sexual orientation). Due to the time and resource constraints of this project, we decided to limit the focus to the criteria stated above.

Summary of Findings

1. *In general, the documents contained more requirements related to linguistic competence than cultural competence.* The most frequently appearing requirements (contained in half or more of the 30 documents) were: specific requirements for providing linguistic services (21); translated written material and signage (19); specific standards related to linguistic services obligations for particular languages based on population thresholds (16); office of diversity/cultural competence organizational plans (16). The next most frequent requirements (appearing in at least a third of the documents) were still heavily weighted towards linguistic competence, but contained two key cultural competence requirements. These included: demonstrating the competence of individuals performing interpreter/bilingual services (14); organized linguistic services (14); communicating the availability of interpreter services to patients (12); diversity training for all staff (12); protocols for culturally competent services (12); continuous patient needs assessment (10); requirements for evaluation of linguistic services and systems (10). A complete list of the elements and frequency of their appearance is contained in the methods chapter.

This finding may reflect several realities. First, many of these documents acknowledge Federal requirements for interpreter services and translated written materials. Currently, no comparable requirements exist with respect to culturally appropriate services. Second, the ability to measure compliance and performance with respect to linguistic access services (number of patients with LEP, number of interpreters, existence of translated written materials/signage) has been perceived as more straightforward than measuring culturally competent performance by either individuals or institutions.

2. *Very few individual source documents could be considered comprehensive in terms of the range of cultural competence activities addressed.* The California Department of Mental Health and the Substance Abuse and Mental Health Services Administration (SAMHSA) mental health services standards come closest, followed by the self-assessment tool from Massachusetts. Several documents are quite explicit with respect to linguistic competence: the Office for Civil Rights-related documents, California's Medicaid managed care and mental health requirements, and Medicaid contract language from Florida and Nebraska.

3. *Many of the operational requirements for linguistic and cultural competence were similar, (and thus combined in the final list of recommendations).* These included requirements for patient needs assessments, community needs assessments, organizational plans/locus of responsibility within an organization, consumer/community involvement, and evaluation of services.

4. *A core set of cultural and linguistic competence activities emerged from the literature and garnered support from the representative group of stakeholders.* The national advisory committee reviewed the analysis of source documents and was able to agree on the content and specific wording for the 14 standards contained in this document, as well as a format for presentation and discussion.

5. *Inclusion of standards in the final list was not based on their frequency of appearance in the source documents.* Frequency was not considered an issue of importance by the advisory committee; indeed, committee members chose to add requirements not contained in the source documents. Remarkably, the final list seems to reflect an increasingly common understanding of what constitutes CLAS (for example, the standards closely mirror the domains of cultural competence identified by Klein's review of cultural competence assessment tools and by Siegel in the tool kit on cultural competence in managed care developed by the Mid American Institute on Poverty).

Implications for Policymakers, Providers, and Consumers

The most significant potential impact of national standards for CLAS is that we can begin to replace the patchwork of different definitions, suggestions and requirements with one universally understood set of expectations. Given that the federal government has begun to mention cultural and linguistic competence in an expanding number of important program rules and regulations, this uniformity of expectations would ideally be started at the federal level.

These recommended standards can also be used to strengthen accreditation standards and review processes sponsored by NCQA and JCAHO. JCAHO standards already show a *general* understanding of the impact of a patient's language, culture, and beliefs on health care. Nevertheless, few health care organizations can be said to be operating in a manner responsive to these goals. Providers and accreditation organizations will benefit when expectations are explicit and detailed, information on operationalizing cultural competence is made available, and mechanisms for review and oversight are specific.

Clearly, specific policy requirements have an impact on service delivery by health care organizations. A recent evaluation of California's Medicaid managed care contract requirements on linguistic and cultural competence shows that providers have responded by making many changes to improve the cultural competence of their services:

"The Medi-Cal requirements have led plans to add staff and establish training programs and services designed to make health care access easier and health care services more effective for multiethnic populations. Prior to contracting with Medi-Cal, most mainstream plans had addressed minority populations only in the context of marketing. All plan representatives reported that their cultural competency efforts are now supporting plan and provider services for non-Medi-Cal enrollees as well—suggesting that Medi-Cal's strategy was indeed seeding greater cultural competence in plan operations aimed at privately insured populations." (Coye)

Specific changes in California's participating managed care market noted in the Coye evaluation include:

- Translation of plan materials
- Improved access to interpreter services
- Community participation in plan services development
- Development of cultural competence training programs
- Increased use of community health workers
- Use of non-commercial plan surpluses for community education, risk prevention, and disease management initiatives
- Greater inclusion of minority physicians and traditional providers
- Creation of a market for vendors of services to support cultural competency and for bilingual employees in health plans and provider organizations.

A close look at the state Medicaid managed care contracts reveals that several states have adopted some of California's cultural competence contract language (although similar evaluations of the impact on service delivery in those states have not been conducted). It is anticipated that the recommended standards contained in this report will be used in drafting model purchasing specifications on cultural competence for inclusion in state contracts Medicaid managed care contracts for the Health Resource and Service Administration (HRSA) Center for Managed Care.

We have yet to fully understand the relationship between culturally competent health services and patient satisfaction/clinical outcomes/health status, and these issues will be more fully explored in the companion report on developing a research agenda for CLAS. We know from many real life examples what can go wrong when patients and providers cannot communicate, or issues of culture are ignored or misunderstood. These consequences are elegantly examined in Ann Fadiman's book, *The Spirit Catches You and You Fall Down*, which depicts a Hmong family's tragic experience with the American health system.

Our literature review highlights studies showing that a lack of attention to cultural issues leads to less than optimal health care, and that addressing these concerns or using certain CLAS interventions leads to improved outcomes. This research does not exist for every population or every type of CLAS intervention—most of it is concentrated on the impact of language or communication barriers—but it is sufficient to suggest that additional work in this area is warranted. We might also consider innovative ways of looking at the existing literature for links between relevant factors that would support the concept of CLAS interventions. Betancourt proposes that one can "connect the dots" between studies on communication, patient satisfaction, adherence and health outcomes to demonstrate that attention to each element has an impact on the next, and a link between improved communication (the heart of most CLAS interventions) and improved health outcomes can convincingly be made. Nevertheless, as we continue to discuss the relationship between CLAS and outcomes, it is important to remember that the vast majority of health practices and protocols in use today are unsupported by research-based outcomes analysis. We must continue to test culturally appropriate interventions, but also hold the rest of medical practice to standards that are evidence-based.

Further work on the relationship between culturally competent services and patient outcomes will also clarify concerns related to the costs and cost-benefits of CLAS. Risk management is incentive enough for some providers who have experienced the results of inappropriate or unnecessary testing, clinical inefficiency, misdiagnosis, negative outcomes, and malpractice due to cultural and linguistic issues. The Mutual Insurance Corp of America sees enough of a link between these factors and liability that it offers a discount on malpractice insurance to physicians who participate in cultural competence training (Trusty). But it is also conceivable that many health care providers and policymakers will be uncomfortable with standards for CLAS because it will involve spending money on the educational, staffing, and organizational changes required to make services more accessible. For example, in the Medicaid program, where significant numbers of ethnically diverse patients are receiving care, reimbursement has never been adequate for the cost of medical services. States may be reluctant to allocate more resources to provide services of adequate quality in an appropriate manner, given the long history of unsuccessful legal and legislative maneuvers to enhance reimbursement for other reasons. The implementation of CLAS may be particularly challenging for private practitioners, community clinics, and public hospitals, the latter two already struggling with large uncompensated care burdens. Accommodations will also have to be made when an organization is small, or is in a rural or frontier area where cultural resources may be hard to come by. For them, it may be valuable to consider government grants to implement networks of culturally competent services, or direct reimbursement from the state for certain services (such as for interpreters in Washington state). But in the for-profit sector, whether through private insurance or in managed care contracts, these services should be considered the cost of doing business. Managed care organizations and other providers should consider the ethics of collecting premiums or reimbursement for services that certain populations cannot use because they are ineffectively delivered or inaccessible. It is even worse to penalize consumers for inappropriately utilizing services because they cannot understand the rules for using them.

It is increasingly common to hear health care providers and analysts speak of the "business case" for addressing diversity. The *Wall Street Journal* has written twice about managed care organizations devising creative strategies to attract or respond to a more culturally diverse clientele. In many areas, ethnic communities are an attractive target for marketing strategies because they represent an untapped "niche" in a shrinking market. Other health care organizations, such as Harvard Pilgrim Health Care and Kaiser Permanente, are strategically addressing diversity issues because of the obvious demographic changes in their communities or because patient/staff satisfaction surveys demand greater attention to CLAS services. Their example may be most instructive, as they attempt to integrate awareness of and responsiveness to cultural and linguistic issues into the whole fabric of their operations.

Conclusion

It was not so long ago that the topic of cultural and linguistic competence in health care mostly drew blank stares from providers and policymakers. The last year has seen a remarkable surge in awareness and

responsiveness to the needs of diverse populations. At the Federal level alone, no less than five major policy initiatives (the adoption of the Consumer Bill of Rights by HHS programs, the Medicare+Choice regulations, the Centers for Medicare and Medicaid Services's Quality Improvement System for Managed Care guidelines, the HHS Office for Civil Rights Guidance on Limited English Proficiency, and the proposed Medicaid regulations) have directly addressed cultural competence in a range of rules that cover nearly every health care provider in the country. The issue has been brought to the forefront—adopting uniform and comprehensive standards will clarify provider and patient expectations and, over time, lead to a consistent and measurable level of services.

Discussion of Research Methods

The project methodology described below was guided by the key tasks and questions mandated by the Office of Minority Health. This section describes the project research questions, sample frame, data collection and analysis methods, and limitations of the design.

Research Goal and Objectives

The overall purpose of the project was to explore what current criteria and tools exist to describe best practices, standards, or performance indicators for cultural and linguistic competence in the delivery of health care services to racial and ethnic populations.

The study objectives that guided this project were as follows:

- Where are we now in the process of developing cultural and linguistic competence standards or performance indicators?
- Do current attempts converge around common themes and elements and can a consensus be developed around draft standards to inform performance indicators?
- What areas require further investigation and/or additional information to develop a consensus?

Research Questions

The research questions sought to investigate whether there is sufficient knowledge and experience within the health care system in developing cultural and linguistic competence standards to form a basis for developing national standards. The following questions served to guide the analysis process:

- What are the common categories of cultural and linguistic competence in existing federal and state and other national policy documents?
- How are performance requirements for cultural and linguistic competence described in each category?
- How do performance requirements compare across similar types of standards (e.g., among OCR consent decrees, or Medicaid contracts)? How do they compare across all types of standards?
- Are there discrete elements that appear repeatedly? How frequently for each category?
- Which elements are the minimum performance requirements in each category? Which are the most comprehensive?
- Do the elements converge around particular performance requirements?

Sample Selection and Data Sources

The types of written documents reviewed for this study included both technical and policy literature.

Technical literature, including reports on research studies, and philosophical and disciplinary papers served as background materials for guiding the coding of cultural and linguistic competence elements; these sources are listed in the Bibliography. The policy literature included legal reports, federal and state statutory and regulatory documents, accreditation guidelines, reports on cultural competence standards or measures, and provider contract documents from select state managed care providers.

In order to address the study questions, we selected 30 policy documents representative of national, federal and state organizations that made specific reference to activities related to cultural and linguistic competence. The 30 policy documents were identified from various sources including:

- the National Health Law Program's (NHeLP) 1998 *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, and included all Medicaid managed care contract language and the summaries of state law requirements addressing language and cultural needs from ten regionally representative states. We also conducted a separate review of the original contracts selected for inclusion, which are on file in the NHeLP-North Carolina office.
- the Center for Health Policy Research's 1997 publication, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*.
- the document entitled "The Office for Civil Rights' 'Bottom Lines' for Linguistic Accessibility", based on NHeLP's review and synthesis of more than 100 compliance agreements or communications from the HHS Office for Civil Rights to health care organizations that are recipients of federal funds. As such, we considered it a *de facto* operating standard with respect to the enforcement of Title VI of the Civil Rights Act of 1964.

All the policy source documents are listed in Appendix 1.

Data Analysis Methods

Data analysis methods employed both quantitative and qualitative techniques. The quantitative methods were driven by content analysis technique to establish discrete measurable units for collating frequency of items within the study documents. The qualitative analysis was guided by a content coding process to identify the common categories and an initial list of areas judged to be important for inclusion under the cultural and linguistic competence thematic clusters.

Documents were reviewed for codes to locate language that was placed under either the cultural and linguistic competence themes. Keywords included, but were not limited to, the following: (1) linguistic services, (2) office of linguistics, (3) language threshold, (4) community advisory committee, (5) protocols for linguistic services, (6) linguistic competence, (7) cultural competence, (8) interpreter/translator services, (9) office of diversity, (10) minority staff.

A matrix analysis format was used to collate information from the source documents. The matrix collated data into two thematic clusters to correspond to (1) linguistic competence (covering the area of language access, interpreter and translation services) and (2) cultural competence (covering the area of patient, staff and organizational cultural diversity management). Originally, each topic area contained twenty elements, which formed the vertical axis of the matrix. Each source document was reviewed and details pertaining to relevant elements were placed in a cell along the horizontal axis. After revisions, the list of elements in each area was reduced to ten and 13, respectively (see Appendix 2).

The ten elements for linguistic competence and the 13 cultural competence elements are outlined below. The initial analysis was drafted into a 23-page preliminary report that addressed similarities and variations in the linguistic and cultural competence requirements that appear in the source documents. Analyses were conducted in two phases: (1) number of source documents that had language corresponding to listed elements, and number of elements addressed (frequency); and (2) language content (substance). The elements are meant to capture the organizational requisites of linguistic and cultural competence, as articulated by the source documents.

Findings and Considerations in Developing Standards

The generated list of elements captures the key characteristics of a culturally competent organization based on a selection of 30 source documents. The sample of source documents is not exhaustive and it is possible that a larger sample would have provided more elements for consideration, or required rewording of language. However, the generated list seems to have face validity because the elements refer to actions that are becoming accepted as enhancing cultural knowledge.

In the table below, the frequently mentioned elements for each topic area are listed, with the number of documents containing each element in parentheses.

Frequently mentioned elements for linguistic competence:

- specific requirements for providing linguistic services (n=21)
- translated written material and signage (19)
- standards related to linguistic services obligations for particular language/thresholds (16)
- demonstrating the competence of individuals performing interpreter/bilingual services (14)
- organized linguistic services (14)
- communicating the availability of interpreter services to patients (12)
- continuous patient needs assessment (10)
- requirements for evaluation of linguistic services and systems (10)
- continuous community needs assessment (7)
- community /consumer input and linkages (3)

Frequently mentioned elements for cultural competence:

- office of diversity/organizational plans (n=16)
- diversity training for all staff (12)
- protocols for culturally competent services (12)
- evaluation/assessment of services provided (7)
- institutional self audit or assessment of cultural competence (6)
- institutional policies & procedures to address discrimination complaints by patients/staff (6)
- determination of ethnic/cultural mix of community (6)
- links with community advocacy groups/consumer involvement (5)
- initiatives to identify, select and retain culturally competent staff (5)
- overall commitment to cultural diversity (4)
- patient ethnic/cultural needs database(4)
- evaluations of training programs (4)
- board of directors, administration, support staff reflect community profile or ethnic mix (3)

Other findings from the analysis related to minimum and comprehensive performance requirements and comparisons across types of standards are discussed in the commentary for each standard that follows.

In considering how the analysis and findings would translate into valid recommendations for national standards, three areas of questions arose:

1. Does the generated list of elements for competence standards provide a practical template for achieving linguistic and cultural competence? Does it reflect current practice in cultural competence and the realities of the health care market?
2. What will constitute a minimum set of standards for cultural competence and how can this set of standards be justified empirically?
3. Can an alternate and exclusive set of standards be generated with equal justification? Should other standards be added to the list?

Recommendations for competence standards must take into consideration what is empirically justifiable and practically viable. Otherwise, the bases for the standards become questionable. As such, while acknowledging the limitations of the study design (using a small sample of source documents), we can recommend a set of standards based on a unifying set of parameters. These parameters are: (1) frequency of terminology or elements and, (2) elements or requisites which may provide support to linguistic and cultural competence efforts; this analysis must also provide

a set of arguably practical recommendations based on current thinking on the subject. The recommended standards have face validity.

However, we determined that Federal requirements themselves constitute a mandatory standard. For example, nearly all providers of health care services in United States are subject to the provisions and interpretations of Title VI of the Civil Rights Act of 1964, enforced by the HHS Office for Civil Rights (these relate primarily to linguistic access issues). As such, these recipients of Federal funds may consider these requirements mandatory, although the OCR guidance to its regional office staff counsels flexibility of implementation, and historically, there have been variances in how providers are called upon to comply in the context of enforcement reviews and agreements. For purposes of this discussion, the OCR requirements and practices will be noted as a critical standard for providers, although not necessarily the highest standard.

We also considered developing standards that would reflect the needs of patients for culturally competent services, knowing that these standards would be considered recommendations and actual practice would vary by organization and circumstance. In the initial review by our advisory committee, all the representatives of health care organizations were comfortable with this approach, provided that the final document described the standards as initial recommendations, subject to further debate and revisions.

The language of the standards is directed towards health care organizations, but can be adapted for use by individual providers. Most of the standards articulate actions that must be undertaken at the organizational level, although many of them encompass individual provider or staff responsibilities. *Organizations* must arrange for interpreter services, translated signage, consumer input mechanisms, and hiring practices that foster diversity. *Individual clinicians and staff* must be educated to address cultural differences in patient encounters, know to request an interpreter if needed, and offer culturally appropriate and translated health education materials. Health care providers working within an organizational structure will best be able to do their job if their institutions support culturally competent practices and services, and they may be able to advocate for this. Providers in private practice may face the greatest challenges, as they may not have access to the same kinds of financial and technical resources as their institutionally-affiliated colleagues.

Furthermore, we initially proposed a more detailed, comprehensive approach to the issues raised by each element—a gold standard, as opposed to minimum requirements. While this led to a lengthier articulation in the first draft of the proposed standards, the later and final versions are more concise, with details related to execution of the standard included in the commentary section.

Initial Recommendations and Subsequent Revisions

Based on the analysis of data in the matrix, the initial report offered a discussion of the frequency and substance pertaining to the final list of elements. The first group of recommended standards (21 in all) had cultural and linguistic competence activities as two separate categories. The report and first set of recommendations for standards were reviewed by a national advisory committee composed of representatives from Federal and state health agencies, provider groups, and academic research, which met in Washington DC in July 1998 (Appendix 3). The advisory committee made recommendations for consolidation of the number of standards and making the language of each standard more concise, with policy and practice implications to be discussed in an accompanying commentary. It also recommended changing the terminology for the draft standards to *culturally and linguistically appropriate services (CLAS)* in health care.

With input gathered from the meeting, a revision of the first set of standards, now reduced to 14, was presented to a focus group convened at the October 1998 national conference, *Quality*

Health Care for Diverse Populations, held in New York City. This version was also distributed for limited public comment on the DiversityRx listserv, from which a dozen comments were received. A second version was drafted in January 1999, and revised four times between February and April 1999 with additional comments from members of the advisory committee.

Commentary On The CLAS Standards

This section offers each standard, in order, as a separate section with commentary. The first part of the commentary contains the findings of the analysis, including a listing of some of the relevant documents. The second part is a discussion of issues relevant to the standard, which may include the rationale for the standard, implementation issues and strategies, and recommendations for policymakers and advocates.

Preamble:

Language and culture have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Health care organizations should promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

Document analysis:

Twelve of the source documents have language related to the provision of culturally competent health care. These included three documents related to mental health and four Medicaid managed care contracts. Some of the language alluding to this requisite are: listing of cultural services; service handbooks, and audio presentations for at least 80 percent of client base; culturally relevant diagnostic tools and the identification and use of literature sensitive to population; development of culturally appropriate health materials and cultural competence protocols; and organizational responsiveness to characteristics of community. Some definitions of cultural competence are also found in these documents. Both the Consumer Bill of Rights and JCAHO standards contain a variety of language addressing this subject, including: the need for providers to strive to overcome cultural and language and communication barriers; the right of the patient to discuss treatment options in a culturally competent environment; the right to considerate, respectful care from all staff members; the right to receive reasonable assistance to overcome language and cultural barriers; the right of patients to express their spiritual beliefs and cultural practices as long as these do not harm others or interfere with treatment; and the need to include these factors in the patient assessment and education processes (JCAHO). The Medicare+Choice regulations require health professionals, coordinated care plans and network plans to provide services and information about treatment in a culturally competent manner.

Discussion:

The need to provide culturally competent health services is articulated in many different ways among the source documents: some language is definitional, but lacks details on implementation; some documents speak more to organizational requirements and others speak to staff behavior. The recommended standards as a whole articulate the many different activities that make up organizational linguistic and cultural competence, but the advisory committee thought it necessary to go to the heart of this issue, and spell out the need for staff to interact with clients in

a way that is culturally appropriate. Given that this ability involves "attitudes, behaviors, knowledge, and skills" that must nearly almost always be learned (or at least supported by a learning process), this standard is inextricably linked with the need for education and training as articulated in standard #5. But as differentiated from #5, this standard is about the need to *behave* in a manner that is culturally appropriate, which can be facilitated by education, but is not guaranteed by it.

The literature offers many definitions of cultural competence and ways for individuals and organizations to become more culturally competent. Not even the term "cultural competence" is universally accepted. Experts speak of cultural awareness, cultural diversity, cultural sensitivity, and other terms. A broad vision of cultural competence is articulated by Lavizzo-Mourey and Mackenzie, and includes being able to recognize and respond to:

health-related beliefs and cultural values (the socioeconomic perspective)
disease incidence and prevalence (the epidemiologic perspective)
treatment efficacy (the outcomes perspective)

The cultural issues that impact health care delivery are complex: they include the "thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment or the problem, and what type of treatment should be given. In sum, because health care is a culture construct, arising from the beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture" (Katz).

Integral to the provision of culturally competent services is familiarity and respect for the traditional healing systems and beliefs of cultural groups. The World Health Organization defines traditional medicine as approaches to protecting and restoring health that existed before the arrival of modern medicine. Traditional systems in general have had to meet the needs of local communities for many centuries. With the growing utilization of complementary and alternative medical practices in the United States, providers are becoming more aware that many of these healing practices have their roots in traditional medicine (including acupuncture, botanicals, massage and therapeutic touch, prayer and other spiritually-oriented healing practices). A culturally competent provider is respectful of these traditions as they are practiced by patients and, where appropriate, integrates these approaches into their treatment plans.

This standard is relevant to both staff and their organizations. Staff are ultimately responsible for the kinds of interactions they have with patients, but they must be supported by managers, systems, and institutions that allow for the realities of culturally appropriate encounters. It involves assessing the demographics of a service area, understanding the characteristics and specific cultural perspectives of that/those populations, their unique and general healthcare needs and using that knowledge in designing services appropriately. This would include working with physicians and other care providers around how to build cultural information into day-to-day interaction with patients. It also informs how services are accessed and organized, including the staffing and scheduling of bilingual, culturally knowledgeable advice nurses in call centers; the expansion of urgent care facilities to meet the walk-in care-seeking patterns of specific populations; the building of larger waiting rooms in facilities serving family-centered cultures; and allowing extra time for a more complex or lengthier encounter. Similarly, managers can better meet their patients' needs by requiring ongoing cross-cultural education for staff, assessing their

skills, and monitoring patient satisfaction with staff encounters. Education, skills assessment, and patient satisfaction surveys will be addressed in more detail below.

2. Health care organizations should have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

Document Analysis:

Overall, 15 of the source documents allude to the need for a structured approach to diversity management. Some of the language includes: presence of cultural competent plan, designation of administration responsible for cultural competence (SAMHSA) and descriptions of ability to provide cultural services to meet needs (Hawaii Medicaid managed care contract). In general, language culled from Medicaid managed care contracts for the states were more detailed than other source documents. For instance, contract language for Nebraska, Pennsylvania, Texas, and Vermont had detailed requirements concerning accommodation of cultural needs of clients within respective service areas; demonstration of cultural competence in service delivery; development of written plans describing cultural competence; and adoption of measures that are culturally sensitive for service delivery. All of these statements refer to the general need for rendering culturally competent services that are not *ad hoc*, but rather organized in terms of specified policies and procedures.

Four source documents allude to the need for organizations to articulate an overall organizational commitment to cultural diversity: Cultural Competence Mental Health Services Plan Requirements, California; Cultural Competence Standards, SAMHSA; Office of Health and Human Services, Division of Medical Assistance, Massachusetts; and Cultural Competence Organizational Self-Assessment, Massachusetts. Language from these source documents referred to the importance of cultural competence in mission statements; inclusion of cultural competence in strategic plans; demonstrating hospital management's attention to cultural diversity including strategy and goals; and adoption of a mission that articulates development of organizational cultural diversity. JCAHO standards refer to planning for services based on characteristics of the member population served, and working to meet community health care needs, addressing cultural diversity and underserved populations (networks). For hospitals, patient care services should be planned and designed to meet the needs of the patient population, which should be identified as part of the planning process

Overall, 14 documents (45%) refer to a requirement for some level of formal organizational structure in the provision of linguistic services. Requirements for written policies or procedures on how to access interpreter services are contained in six documents. Nine documents require the provider to maintain a list of staff /on-call interpreters, bilingual staff, or language services. Requirements for policies related to the competence/training of interpreters are contained in five documents. Policies regarding notation of linguistic needs in patient records are contained in one document, and requirements for specific coordinating staff are contained in two documents.

California's Medi-Cal managed care regulations contain the most extensive requirements for organizational formality in the provision of culturally and linguistically appropriate services, including the development of cultural and linguistic services plan, with activities, time lines, milestones, identification of responsible individuals (including organizational charts, types and responsibilities of staff), the development and implementation of standards and performance requirements, performance monitoring, and protocols for appointment scheduling and system coordination.

Both the HHS Office for Civil Rights (OCR) 1998 guidance and the National Health Law Program (NHeLP) review of OCR compliance agreements with providers speak to the need for formal structures for ensuring access for clients with limited English proficiency (LEP) at facilities

receiving federal funds. The OCR guidance recommends a structured rather than *ad hoc* approach to ensuring LEP access to services and describes acceptable methods for developing policies and procedures to accomplish this. The NHeLP review notes that federal funds recipients have been required to: develop written policies for staff and to ensure the awareness of the existence of those policies, develop a system for tracking LEP clients and their needs; and identify a single individual or department charged with ensuring the provision of linguistic services.

Discussion:

As noted in the discussion of findings, OCR recognizes that it is very difficult to deliver linguistic services to a diverse patient population according to the Federal standards of timeliness and appropriateness if a formal structure for organizing and accessing these services is not in place. For example, having qualified interpreters and translated materials available at the time of need is nearly impossible without staff who are responsible for organizing and dispatching the services. A similar argument can be made for overall organizational cultural competence—or elements, such as appropriate food choices in a hospital, or cultural competence training for all staff. This would include the more subtle indicators of a culturally competent environment: the inclusion of culturally appropriate magazines and health education materials in the waiting and treatment rooms, the use of culturally appropriate artwork and posters, the design and decor of the health facility.

The majority of documents referred to the need for establishing an office of diversity with formal policies and procedures to manage workforce and community diversity, and the need for protocols for the provision and delivery of cultural competent services. These findings confirm that a culturally competent organization must first establish formal pathways for managing diversity, and support previous studies (Ginsberg) that have reported that linguistic or cultural competent services are most successful when they are not done in an *ad hoc* manner. However, as these findings suggest, although a formal office of diversity may be necessary for the provision of competent services, it is not sufficient. An organization that approaches cultural competence must also have clearly delineated procedures for service delivery.

Whereas an overall organizational commitment to cultural diversity or the inclusion of such language in organizational strategic goals may provide symbolic promises, the lack of such language does not imply that the organization is inadequate in its cultural knowledge of consumers or is not adequately providing health care to its diverse patient population. But such language can be an important way for administrators to focus attention and resources on the activities that must necessarily follow. Especially in large and complex organizations, an overall organizational commitment could be essential to ensuring that attention to culturally appropriate services is pervasive throughout all units, and transcends the efforts of individual staff who may not remain with the organization.

3. Health care organizations should utilize formal mechanisms for community and consumer involvement in service delivery design and execution, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.

Two documents specify requirements to consult with community representatives on issues related to the linguistic competence of the provider. The OCR guidance recommends consultation with organizations and groups in service areas on language needs and services. California's Medicaid managed care regulations require plans to implement and maintain links with the community through advisory committees, with participation from consumers, advocates, and safety net providers. The responsibilities include advising on educational and operational issues regarding linguistic and cultural competence. Other states also combine linguistic and cultural competence services in requirements for community consultation and linkages with providers. Five source documents referred to this element: Cultural Competence Mental Health Services

Plan Requirements, California; Cultural Competence Standards, SAMHSA; California Medi-Cal Managed Care Local Initiative; Medicaid managed care contract language, Pennsylvania; and Cultural Competence Organizational Self-Assessment, Massachusetts. Sample language referred to the need for developing relationships with local boards, community organizations; creation of ombudspersons composed of consumers; and collaborations with community representatives in planning and service delivery. The JCAHO standards make extensive references to patient/client involvement in care planning through inclusion of spiritual, social, cultural, and ethnic factors in assessments, nutrition, education, and other treatment decisions involving standards on behavioral health, long term care, and home care.

Discussion:

Consumer input into the design and implementation of health care services is a well-established practice in some types of organizations (i.e., community health centers), merely a formality or is nonexistent in others. Given the complexity of deciphering the cultural beliefs and mores of ethnic communities, health care organizations would appear to benefit greatly from establishing ongoing links and opportunities for consultation with representatives from these communities. On the other hand, for some, it may also raise the specter of opening the door to painful criticism and unlimited or unachievable demands.

California's Medicaid managed care RFA requires managed care organizations to develop a formal committee to provide input, expertise, and oversight of cultural and linguistic services. The Alameda Alliance for Health's Community Advisory Committee consists of individuals from community based organizations, advocacy groups, and providers who represent the diverse ethnic communities in Alameda County. The group meets quarterly for about two hours. Over the past two years, the Committee has: (1) reviewed and approved all plans for cultural and linguistic services, including all translations of materials; (2) helped design the needs assessment, reviewed focus group recruitment and helped identify community resources; (3) proposed establishment of an ombudsman program for Medi-Cal beneficiaries enrolled in managed care; and (4) served as a liaison with community organizations and advocacy groups. In addition, the Committee reviewed plans for the first satisfaction survey. Their suggestions led to the development of a 'Neighbor to Neighbor' Survey Project, enlisting, training and paying welfare recipients as Community Field Workers to conduct member satisfaction surveys over the phone and in household visits; 66 percent of the 490 surveys were in languages other than English (Coye).

There is also the issue of developing formal participation and referral linkages with ethnic and community-based providers and resources for cultural and linguistic services. This too may have the effect of assisting mainstream providers with resources and expertise which may be otherwise difficult and costly for them to successfully replicate. Again, as a result of the Medicaid managed care rules in California, some plans and providers have realized that the ongoing member education and chronic disease or prenatal care management of non-English speaking patients can be difficult and time consuming for providers who are not from the same ethnic group. This has led to increasing experimentation with the use of community health workers, both by providers and by plans. In light of the limited contact time between patients and clinical providers in most health care settings today, the development of community health worker programs may offer an effective means of educating and supporting the continuing health management needs of all patients (Coye).

Finally, providers need to be open to patient (and family, as appropriate) involvement in treatment plan negotiation and development. This goal is clearly articulated in the mental health standards from the source documents, and is also part of JCAHO standards. This concept is not nearly so unusual as it might seem—the literature shows that patients in high socioeconomic status groups take a very participatory role in their treatment, and the advent of HIV/AIDS witnessed redefinition

of the relationship between patients and providers, with patients taking a very active and in some cases, co-expert role in medical encounters. The relationship of equals can be a model for cross-cultural encounters. Patients and their families are experts in their own beliefs and health traditions, and clinicians offer the expertise of biomedicine. Successful encounters will seek to acknowledge and integrate these resources.

4. Providers should develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that represents the racial and ethnic communities being served.

Document Analysis:

Five source documents suggest initiatives to identify, select and retain culturally competent staff. Documents generally referred to the recruitment of minority groups and persons with special or culturally competent skills at all levels including medical staff, hospital administration and senior management. Culturally competent skills are not explicitly defined. Of the five source documents, three call for a board of directors, administrative and/or support staff that reflect community profile or ethnic. Sample language called for incorporation of boards that were at least 90 percent proportionally representative of community; documentation and identification of minority participation in executive level decisions and whether or not key administrative positions were filled by minorities; and medical staff and senior management that were proportional to population or client mix. The Consumer Bill of Rights addresses the right of consumers to receive information about the language spoken by primary care and specialty providers, but does not mention language/ethnicity as a consideration in the "Choice of Providers and Plans" standard.

Discussion:

The rationale for this standard is perhaps most obvious with respect to staff that have direct patient contact, especially clinical staff. Bilingual-bicultural staff will have greater likelihood of facilitating communication directly with patients whose language they are proficient in, and may be more sensitive to certain cultural issues. However, since country of origin, acculturation levels, social and educational standing may vary considerably among individuals, this sensitivity cannot always be assumed. Therefore, these staff should receive cultural competence training, as they will inevitably interact with patients and families whose cultural background may be unfamiliar.

The difficulty in implementing a policy of recruiting staff to reflect the community being served is that representational parity for racial/ethnic individuals in the health professions does not exist, especially for clinical positions. Competition between health organizations for staff from diverse backgrounds is keen, and there are never enough individuals to fill the increasing number of positions that call for bilingual-bicultural skills. Clearly this is a problem that must continue to be addressed at the national level, by way of improved recruitment into, and retention in health professions programs, starting as early as junior high school. But it is also realistic to assume that in many cities with highly diverse populations, it may not always be possible to construct a staff that adequately mirrors the diversity of the patient population.

Nevertheless, most health care organizations can make significant improvements in this area. One model developed by the Asian Counseling and Referral Services in Seattle, WA, is to "grow your own." Individuals are hired from the communities being served and trained to act first in an interpreter-cultural broker capacity in counseling sessions. They participate as co-providers in the encounter, adding their expertise about the language and culture to the clinical expertise of the mental health professional. These liaison staff are encouraged to pursue formal training in the health professions, so that in time, they will be able to treat patients directly.

Another example is the expanding utilization of cultural brokers/case managers/outreach community health workers. These individuals can, with proper training, play a multi-functional role in bridging the gap between mainstream organizations and ethnic minority communities. The Harborview Medical Center Community House Calls program uses two kinds of cultural patient liaisons. Interpreter Case Managers are bilingual/bicultural individuals who interpret in clinic settings and act as outreach workers in the community. They explicitly address both language and cultural issues in encounters. The Community Advisors are the selected representatives of each cultural group served by the hospital, and they educate staff about the social needs and concerns of their communities. Another model is the well-developed promotora model, which performs health education and outreach initiatives. Their roles could be expanded to provide a number of liaison functions in large and small organizations, especially those that serve a number of different ethnic groups and may have difficulty hiring bilingual/bicultural staff for all patient contact points.

The concept of co-providers is important. Many organizations will use non-clinical support staff in these liaison/culture-broker positions—sometimes appropriately, with training, and sometimes inappropriately, as in using cleaning staff as *ad hoc* interpreters. Bilingual-bicultural staff can be a tremendous asset to an organization if properly respected and incorporated. They can offer insight and community knowledge for program design and implementation, and they can speak up for the needs and interests of the communities being served by the institution.

In sum, bilingual-bicultural staff can interact directly with clients from similar backgrounds, and they can work to ensure that the needs of those patients are always considered in administrative decisions and structures of the organization. They are both a sign of an organization's cultural competence, and a motivating force to make the organization's services increasingly relevant and effective for its clientele.

5. Health care organizations should require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

Document Analysis:

Eleven of the source documents refer to training in culturally and linguistically competent service delivery: OCR's Bottom Lines for Linguistic Accessibility; Cultural Competence Mental Health Services Plan Requirements, California; New York Cultural and Linguistic Standards; Cultural Competence Standards, SAMHSA; California Medi-Cal Managed Care Local Initiative; Medicaid managed care contract language, Colorado; Medicaid managed care contract language, Massachusetts; Medicaid managed care contract language, Pennsylvania; Medicaid managed care contract language, Texas; Office of Health and Human Services, Division of Medical Assistance, Massachusetts; and Cultural Competence Organizational Self-Assessment, Massachusetts. Sample language from these documents called for continuous training and certification in cultural sensitivity and cultural competence; documentation that 100 percent staff (clinical and all direct medical care staff, and non clinical staff) are trained in cultural competence and receive at least 10 hours training and 100 percent access to cultural competence information; evidence of cultural competence training protocols or curriculum as well as policies and guidelines for competence training; commitment to cross-cultural training and orientations in specified language groups in service area. The Consumer Bill of Rights suggests enhanced health professions training on the role of culture in health care, and continuing education courses for providers to assure cultural and language competency under its "Participation in Treatment Decisions" and "Respect and Nondiscrimination" standards.

Four source documents made reference to the continuous formal evaluations of training programs: Cultural Competence Mental Health Services Plan Requirements, California; Cultural Competence Standards, SAMHSA; California Medi-Cal Managed Care Local Initiative; and

Cultural Competence Organizational Self-Assessment, Massachusetts. Language of these documents generally called for certification and credentialing standards of competence; and continuing performance-based evaluations focusing on achievement of stated objectives of competence training.

Discussion:

This may be the single most important element of assuring the cultural competence of an organization, and one of the elements most directly related to clinical care and outcomes. Although not widely practiced, it is possible to require and verify that staff receive this kind of education—more so if the organization where they work offers the training. However, there is no consensus on the definition of cultural competence, and what constitutes a culturally competent health professional is also subject to varying definitions. This does not mean that the area is not well traversed; on the contrary, definitions, resources, training programs, curricula, and purveyors of all the above abound. The main challenge for anyone seeking to attain cultural competence is trying to determine what the training should be and who should do it, as there is no standard curriculum, nor universally accepted certification or credentialing. Outside academic settings, continuing education courses and courses designed for individual organizations or groups of staff range from a few hours to a few days. There are many consultants and trainers teaching cultural competence to health professionals. Their credentials range from no formal training to previous experience in human resources diversity training to doctoral level research and academic training experience in cross cultural issues (i.e. medical anthropology, medical sociology, transcultural psychology, intercultural relations). Each trainer develops his/her own content and teaching approach, and both vary widely. For example, a common method of teaching cultural competence is to provide a general overview of the role of culture in health service delivery, and then to spend time focusing on the health beliefs and behaviors of specific ethnic groups. While this has the effect of increasing general knowledge about an ethnic population, it can lead to facile stereotyping if improperly conducted or understood. It has been debated that utilizing a more universal skills approach to cultural competence allows practitioners to use general questioning and medical history-taking techniques on any individual from any ethnic background—a more useful approach for health facilities that see a wide diversity of clientele (e.g., Kleinman, Berlin). This skill could be combined with intensive education about specific ethnic groups.

Given the absence of a standardized curriculum and evaluative measures, it is difficult to discern the relative quality of the training programs when compared to one another, and this is an issue that must be addressed in order to fully assess individual or organizational competence, especially if participation in training becomes one marker of competence.

Persuading staff and organizations to undertake cultural competence training may also be problematic. Health professionals often reject long cultural competence training sessions unless they are required by credentialing bodies or the organizations they work for. This is one of the reasons that this standard asks organizations to require it. When staff undertake training, they are often frustrated in their attempts to practice new skills in what may still be a culturally incompetent organization. And organizations are often reluctant to take time for organization-wide training, either because of the cost, the disruption, or the reality it forces them to face about their institution's cultural insensitivity that staff training might not completely address.

Theoretical knowledge about cultural competence is not enough, and this is one of the reasons for health care organizations to customize aspects of this training to address the needs of their own institutions. For example, staff should be aware of an institution's policy and procedures for providing interpreter services, preferably as part of employee training or orientation. Staff should have tools and guidelines on how to use interpreters, (e.g., "Interpreter Services 101,") and should understand the consequences if the service is not provided.

A key component of many cultural competence training programs are tools for individuals and health care organizations to assess their own cultural competence and the competence of staff. Several of these tools have been developed and have been reviewed and catalogued by a number of researchers and agencies (e.g., Judge Baker Children's Center, Mathematica Policy Research, Inc.); however, they are not rated against each other. One tool, developed by Miguel Tirado was based on extensive research with Chinese and Latino patients and physicians, and has recently been modified for use in managed care settings.

On a more general note, a review of the measurement and assessment literature conducted by Armando Estrada indicated that many of the tools lack reliability and validity. Many of tools are questionnaires that presumably ask valid and representative questions about cultural competence. The answers presume to reflect reliable and accurate information about respondents assessment of cultural competence services. Yet, there is no empirical evidence to validate many of these measures (i.e., representative of the construct of cultural competence) or reliable (i.e., that they provide accurate information about cultural competence).

Ideally, training and skills assessment for cultural competence should be integrated from the earliest phases of health professions training through the professional licensing process. Some programs have long histories of addressing these issues, others are just beginning. In academic settings, cultural competence training ranges from semester-long courses to discrete components that are part of a broader course outline. Based on ten years of development, the Society of Teachers of Family Medicine (STFM), has published curriculum guidelines for teaching culturally sensitive and competent health care to family medicine residents and other health professions students. The University of Washington-Seattle started a cross-cultural nursing track at the School of Nursing in 1974, and similar programs exist at the University of Miami, the University of California-San Francisco, and the University of Utah. Many other health professions training programs across the country have specialized coursework in this area or faculty who are conducting research or teaching on cross cultural health issues. Both the Association of American Medical Colleges and the DHHS Office of Women's Health have surveyed medical schools for information on their cultural competence curricula and programs.

6. Health care organizations should provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

Document Analysis:

Twenty-one documents articulate requirements for providing linguistic services to individuals with LEP. Twelve documents state an unequivocal client right to access/or provider responsibility to offer interpreter/bilingual services. Eight documents qualify this right with language such as: "if language barriers present a continuing problem" to patient understanding of care and treatment; "best efforts to provide reasonable access" to interpreter services as needed to ensure communication; "as necessary" to ensure availability of effective communication regarding treatment. In several different standards, the Consumer Bill of Rights recommends that providers "strive to" provide reasonable assistance to overcome language barriers, including onsite interpreters. The right to "effective communication," through bilingual staff or interpreters is prominent in all JCAHO standards. The OCR guidance and the NHeLP review of OCR compliance agreements take slightly different approaches to articulating requirements for providing linguistic services. The OCR guidance as a whole offers detailed recommendations on how providers can meet their Title VI responsibilities vis-a-vis access to services for individuals with LEP, and states in the memorandum that recipients of federal funds "should take reasonable steps to provide services and information in appropriate languages other than English in order to ensure that LEP persons are effectively informed and can effectively participate in and benefit from its programs." The NHeLP review summarizes the provisions of OCR compliance agreements as follows: "Recipients of Federal funds have an obligation to offer translation

services at no cost to LEP individuals." Altogether, three documents specifically mention that these services should be provided at no cost to the client.

Nine of the 18 documents specify how these services should be provided: i.e., through qualified interpreters; through interpreters or "other alternatives"; in person where practical and telephone services otherwise; through primary care providers in their own language; through a choice of two multilingual providers; through bilingual Spanish providers wherever Spanish speaking enrollees obtain services; and through interpreter services if accessing a bilingual provider is not reasonable.

Overall, 15 documents make reference to methods of delivering linguistic services (the qualifications of interpreters is discussed separately under standard #9). Five documents refer specifically to a requirement for 24-hour availability of interpreter services. The OCR guidance specifies the need for availability of interpreter services during a facility's hours of operation. The NHeLP review states: "Recipients need to ensure the availability of a sufficient number of qualified interpreters on a 24-hour basis. There should be ready access to qualified interpreters so that services are not denied or delayed." Ten documents deem telephone interpreter services permissible or acceptable, although three specify that in-person services are preferable, or that telephone services should only be used in an emergency or when no staff or contract interpreters are available. Both the OCR guidance and the NHeLP recommend speak to using telephone interpreter services as a supplemental system. The guidance warns that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service. As such, special arrangements may have to be made to use interpreters familiar with terminology. The NHeLP review notes that the use of telephone translation should be limited to situations where there is no bilingual staff person or contracted interpreter available to provide translation services.

Sixteen documents specify which languages interpreter services should be made available in. The most comprehensive document challenges providers to offer services to 100 percent of LEP in the service area, and 100 percent in their preferred language (SAMHSA). While OCR is silent on the question of thresholds in their guidance document, most of the compliance agreements reviewed by NHeLP suggest that each individual needing interpreter services is entitled to receive them.

One state recommends a threshold of 100 persons whose first language is not English/cannot read English at a 6th grade level; one state recommends 100 persons in each language group in a county as the threshold; one state suggests that 500 persons constitute a "major population" for whom accommodations should be made; and in another state 3,000 in a service area, or 1,000 in one zip code, or 1,500 in two contiguous zip codes. One state requires services for the three most common languages in the area, another requires that the member handbook be translated into at least in three other languages (without specifying which). Another state requires interpretation/translation services in a list of languages and "other languages designated as appropriate" by the department. Finally, there are several thresholds based on persons with LEP as a percentage of a given population. These range from greater than five percent of the population in a county, district or service area; to 10 percent or more of the HMOs Medicaid service population; to a combination of percentage and numerical thresholds (5 percent or 3,000 in a county or within a service area).

Discussion:

1. Requirement for providing linguistic services:

OCR seems fairly clear that health care providers have an obligation to bridge language gaps between their staff/systems and clients. While many of the documents analyzed may not

specifically state a requirement for providing linguistic services, nearly all of them imply this responsibility by addressing mechanisms for delivering interpreter, bilingual, or translation services. The critical issue here is not necessarily how services should be provided (this is dealt with separately below); it is simply whether or not providers have an obligation to provide them, and clients can expect to receive them. Given the extensive literature and practical experience related to the impact of communication distortions between patients with LEP and monolingual English providers, it seems clear that not providing linguistic access services would increase incidence of miscommunication, misdiagnosis, inappropriate treatment, reduced patient comprehension and compliance, clinical inefficiency, decreased patient and provider satisfaction, malpractice, injury, and death. Providers may intuitively or explicitly realize this, however many institutions find it inconvenient to address this issue without externally articulated requirements and obligations. The practical experience of OCR demonstrates this: enforcement actions have been taken against certain hospitals and other health agencies for at least two decades, and comprehensive language access systems have resulted from these actions. Nevertheless, a large percentage of health care providers are still unaware of their Title VI obligations, and the unavailability of linguistic access services is common.

2. How to provide language access services:

Oral interpretation services should be made available by health care organizations for all LEP individuals, using a combination of methods that may include, in order of desirability: bilingual staff, face-to-face interpretation, and telephone interpretation services. HHS and other state and private regulatory agencies should spell out Title VI requirements on this issue, and increase resources to educate providers and conduct oversight on compliance.

3. Determining which languages and population thresholds:

As noted, the OCR guidance is silent on the question of thresholds, while most of the compliance agreements reviewed by NHeLP suggest that each individual needing interpreter services is entitled to receive them (most complaints that lead to compliance reviews and remediation are filed by individuals, and are a response to an individual's, not a group's, civil rights violation). In spite of this apparent standard by the Federal government, most of the other documents reviewed for this report articulate some kind of threshold for the provision of linguistic services. Those with straight percentage cutoffs are perhaps the most arbitrary—depending on the density of a particular population in a service area, hundreds and thousands of LEP individuals could be excluded from receiving interpreter services or translated materials. This possibility was recognized in California, and a combination of percentage/numerical threshold was developed. However, this threshold related only to the provision of translated written materials; contractors with the Medi-Cal managed care program are instructed to have oral interpretation services available for all LEP individuals (these can be delivered in person or through a telephone interpreter service). As long as OCR continues to enforce Title VI language access rights for individuals, it would appear that the California methodology would be the most consistent with Federal law.

7. 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 interpreter services free of charge.

Document Analysis:

Twelve documents contain requirements that providers should communicate the availability of interpreter/bilingual services to clients. Several are non-specific as to how this information should be communicated; others suggest methods of communication that include posting translated signs (Florida specifies in English and in Spanish), and providing information in health plan

member handbooks on how to request accommodation for special needs (i.e. interpreter services or translated documents). California's Medicaid managed care RFA requires that applicants describe how they will inform members and community groups/organizations of the range in availability of translation services and how to access and utilize the services. They must describe the type of community outreach efforts to promote the services in different languages, and the types of materials, the content, locations and events where these materials will be made available, and signage posted. The Consumer Bill of Rights addresses the right of consumers to receive information about the language spoken by primary care and specialty providers. The OCR guidance addresses this issue by stating that "the LEP client should be given information about, and be able to understand, the services that can be provided by the [provider] recipient to address his/her situation and must be able to communicate his/her situation to the recipient service provider." The OCR guidance also suggests that providers disseminate interpreter policies and procedures to staff about their Title VI obligations to persons with LEP. Some of the compliance agreements reviewed by NHeLP suggest additional steps for providers to take, including the following: providers should publicize the availability of no cost programs and services in non-English community newspapers and on non-English radio and television stations; providers need to issue written notices to clients in their primary language informing them of their right to receive interpreter services; providers should inform LEP individuals of the availability of no cost interpreter services; and recipients should conduct community outreach to give notice to community agencies and referral sources about the facility's new [interpreter] policies.

Discussion:

It is frequently a challenge for individuals with LEP to access interpreter/bilingual services, even when an institution organizes and offers the services. At one large hospital in California with a million dollar interpreter services program and over 30,000 encounters per year, a former interpreter services coordinator estimated that perhaps 30 percent of all patients who needed an interpreter did not get one, most likely because staff were too busy to make a request to the interpreter services office. The availability of services is no guarantee that they will actually be used when the need arises. And without information about them, many LEP individuals would not think or would be hesitant to ask a provider to supply an interpreter. Both the OCR and NHeLP documents (as well as 9 others) recognize the need to inform clients of the availability of interpreter, bilingual, and translation services, and many of these documents go beyond requiring that providers inform clients only at the time of accessing services.

Facilities around the country have developed innovative ways to publicize the availability of bilingual/interpreter services. At the University of Massachusetts Medical Center in Worcester, the staff at the main informational kiosk direct incoming LEP patients to a sign on the wall that has tear-off cards in many different languages. The patient selects the appropriate card for their language and hands it to the staff person, who then contacts interpreter services. At the Pacific Medical Center Clinics in Seattle, WA, all new patients are automatically assigned an interpreter in their native language who appears at each visit unless the first visit reveals that the interpreter is unnecessary. At the community level, the Heartland Alliance in Chicago, IL, has published bilingual wallet cards that inform the carrier and any provider who receives it that the holder of the card is LEP and entitled to interpreter services under state and Federal law. The cards are distributed to individuals through community-based organizations and the carriers are instructed to present the card when seeking health services. NHeLP notes that OCR compliance agreements require providers to conduct outreach to communities to publicize the availability of no-cost programs and services in non-English community newspapers, radio and television stations, and give notice to community agencies and referral sources about the facility's language access policies. Many providers, especially managed care organizations, have found that advertising the availability of bilingual services can increase enrollment from targeted communities.

State and Federal laws, regulations, and contracts with health providers should reiterate, in detail, the Title VI provider obligation to inform recipients of their right to receive no-cost

interpreter/bilingual services. Accreditation standards and measures should reflect and refer to relevant Federal laws, including Title VI. Oversight agencies and advocates can check compliance by entering facilities to see if appropriate signage and notices are posted, and by calling facilities to inquire about availability of interpreters/bilingual staff. Staff should be instructed in the organization's Title VI and other legal responsibilities, and understand institutional procedures for securing interpreter/bilingual assistance.

8. Providers should translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.

Document Analysis:

Nineteen documents address requirements for translated materials, signage, or alternative formats. Requirements related to translated signage (7 documents) primarily deal with the need to post notices about a variety of patient rights, including the right to charity care, rights of Medicare beneficiaries, rights and responsibilities regarding reporting of patient abuse and freedom from retaliation, and general patient rights. Some specify thresholds for how many languages these notices must be translated into--these include: English and Spanish (Florida); languages for which residents constitute 10 percent of the population (community health centers in Massachusetts); and "languages representative of the makeup of the community." Requirements for written materials include: approval or verification of accuracy of written materials (4 documents); use of "alternative formats" for LEP or illiterate clients, including translations of documents delivered orally (4 documents); thresholds triggering need to translate materials (specifically identified languages – (5 documents); and "languages of major populations as defined by federal guidelines -- 10 percent or more of the service population" -- (1 document); translations of specifically identified patient education material on mental health services (1); patient rights (1); health plan member handbooks (1) written materials generally (12); marketing, pre-enrollment, and application materials (1); patient education and outreach materials (2); essential brochures, forms, and notices used by patients (1); all disenrollment instructions and grievance procedures (1); promotional flyers, booklets or other service overviews (2); and contracts negotiated between the states and providers or beneficiaries (1).

The Consumer Bill of Rights notes that information about health services should be made available in "useful and appropriate formats," with assistance for vulnerable populations such as non-English speakers. JCAHO requirements vary from standard to standard, but generally state that when written communication is not effective for conveying patient rights, the information should be repeated in a manner or language patients can understand (network standards specify that the patient must receive a written statement of rights and other patient services in a language they understand when receiving treatment in an organization). The standards also address the need for educational materials and signage that take into account patient literacy, educational levels, and language.

Based on compliance agreement reviews, NHeLP recommends that "translated written materials should be available. Thus recipients will need to identify essential brochures, forms, and notices used by patients and translate them into appropriate languages." The OCR guidance provides more explicit information, citing government-wide Title VI regulations issued by the U.S. Department of Justice (DOJ): "Where a significant number or proportion of the population eligible to be served or likely to be directly affected by a Federally assisted program needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

Discussion:

This was one of the most frequently articulated requirements for linguistic access services. Some of the important questions surrounding the provision of translated written material include: (1) What material should be translated, and for which language groups? (2) How can material be translated? (3) How should the accuracy and appropriateness of translations be assured? Analysis of the findings suggest that most documents have a general requirement for the translation of written materials and signage, and this is supported by the NHeLP analysis of compliance agreements which speaks of "essential brochures, forms, and notices" translated into "appropriate languages." As noted before, the OCR guidance deals primarily with oral interpretation obligations, but makes reference to a DOJ regulation regarding taking "reasonable steps" towards the distribution of translated written material.

With respect to defining "predominant languages" for which materials should be translated, the Federal standard articulated by the DOJ is five percent of the population served. Other rules vary, but at minimum, healthcare organizations should be familiar with any national, state or local regulations related to provision of language services and they should make sure that information about these requirements are disseminated widely to those people who should know about them: i.e., member services, personnel member communications, personnel health education, personnel outreach, advertising and public relations, as well as direct service provider personnel. Appropriate multilingual signage may be especially difficult in institutions where more than one language is predominant.

With respect to translation methodologies and review, only a few agencies (public, nonprofit, and private) have developed guidelines, and ongoing research is examining the validity of different methodologies with the aim of yielding accurate and understandable documents. At a minimum, professionally accepted standards include translation by a trained individual, back translation, and review by target audience groups. These minimum standards direct translation of complicated jargon and concepts that are essentially untranslatable or require further explanation. However, many experts believe that even with these standards, many documents are better approached through a method of developing written material in the target language collaboratively with the target community and the writer of the substantive material. This methodology, however, is not convenient for translating the vast amount of written material being promulgated by health providers today, especially managed care organizations.

The quality of written translations and competence in translating is as important as in oral interpretation. At the least, providers should have in place written criteria for selecting translation vendors, including: 1) a review of the methods and procedures that are used, from submission of English copy to printing of finished materials; 2) how translators are recruited and trained; and 3) how review of translated material is accomplished. They should also have in place knowledgeable people to work with the vendors. Similar criteria should be in place for determining the quality of purchased translations. There should be written policies forbidding "wildcat" translation (e.g. the doctor's sister who took Spanish in college).

Consideration should also be given to the readability of written materials beyond language differences, including making accommodations for:

1. native English-speakers with low literacy, especially the elderly;
2. persons with visual, developmental, and/or cognitive difficulties;
3. limited English speakers who may not read well in their first language; and
4. persons whose languages lack a written version.

9. Health care organizations should ensure that interpreters and bilingual staff can demonstrate bilingual proficiency, and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered appropriate substitutes because they usually lack these abilities.

Document Analysis:

Fourteen documents address the issue of competence or qualifications of individuals providing bilingual/interpreter services. The language relating to competence varies widely among these documents: two documents refer to use of "professional" interpreters (although one adds to this: "where use of family or friends is inappropriate." Two documents refer to "qualified" interpreters, one of which (Washington State's Medicaid managed care contract) adds that this should be someone who can demonstrate "a high level of expressive and receptive skills and a thorough knowledge of the Code of Ethics on interpreting, or a person who speaks English and another language fluently enough to accurately and effectively enhance communication... [f]luency includes an understanding of nonverbal and cultural patterns to effectively communicate in a language." The Washington document further states that the Department will pay only those interpreters who are certified and have entered into core provider agreements with the Department (Washington has a voluntary certification program for interpreters and pays them directly or through contract arrangements with providers or interpreter broker agencies).

Three documents besides Washington's refer to certification for interpreters as preferable (one refers to formal skills certification for bilingual staff), three refer to the establishment of performance standards and other policies regarding the demonstration of interpreter competence, two require an assessment process to assure the basic competency of interpreters, and three require evidence of training programs for bilingual staff or others acting as interpreters. Massachusetts's quality standards for hospitals include a requirement that hospital-based interpreters be members of the Massachusetts Medical Interpreter Association. NCQA's HEDIS standard related to the use of interpreters states that "determination of the training of interpreters or quality of the service is beyond the scope of the standard."

The OCR guidance states that recipients of Federal funds should ensure they use persons competent to provide interpreter services: "Competency does not necessarily mean formal certification as an interpreter, though this certification generally is preferable. However the competency requirement does contemplate proficiency in both English and the other language, orientation or training which includes the ethics of interpreting, and fundamental knowledge in both languages of any specialized terms and concepts peculiar to the recipient's program or activity." The guidance discusses the different abilities of medical staff who may be partially bilingual to act as competent interpreters. In discussing the use of staff or community volunteers or contract interpreters, the guidance states that such individuals should be qualified, trained, capable of ensuring patient confidentiality, and readily available. These requirements apply also to paid interpreter staff and contract telephone interpreter services (OCR also notes that, with respect to paid staff interpreters, "in most instances these employees are salaried and are entitled to the same benefits received by other employees.") The NHeLP review reflects these requirements by stating that "[I]nterpreters need to be qualified and trained, with demonstrated proficiency in both English and the other language, knowledge of specialized terms and concepts in both languages, and the ethics of interpreting. Staffing levels need to be maintained, and skills and fluency of interpreters should be evaluated on an ongoing basis."

Seven documents speak to the issue of using family or friends for client interpretation. Six state that family and friends should not be used, although two allow that they may be used if requested by the patient, and one document allows it if it is an emergency. Three documents specifically speak against the use of children as interpreters. The OCR guidance states that recipients of

federal funds should not require a beneficiary to use friends or family as interpreter, although they do allow that such individuals may be used if: this approach is requested by the LEP individual, the use of such a person would not compromise the effectiveness of services or violate the beneficiary's confidentiality, and the beneficiary is advised that a free interpreter is available. The NHeLP compliance review echoes this policy, and further stipulates that minors should not be used to translate. However, the JCAHO accreditation manual for home care uses an example of a home care organization with a large caseload of Spanish-speaking patients, noting that when it assigns a staff member who does not speak the patient's language, the organization requires a family member who can translate to be present at any home visits. If this is not feasible, it should maintain a list of available interpreters.

Discussion:

Given the widespread prevalence of *ad hoc* and untrained interpreter services, it is perhaps surprising to read about the level of recognition exhibited in the review documents on the need for competency of bilingual/interpreter staff. The research of Downing and others on the impact of using untrained interpreters makes clear that the error rate of untrained "interpreters" (including family and friends) is sufficiently high as to make their use more dangerous in some circumstances than no interpreter at all; this is because it lends a false sense of security to both provider and client that accurate communication is actually taking place.

However, despite the recognition that interpreter competence is important, exactly what competence means is mostly not articulated in the reviewed documents. "Professional" could simply mean "paid." "Trained" and "certified" may not mean trained or certified in *medical* interpretation, which requires a different set of skills, ethical considerations and, most importantly, technical language, than court or conference interpretation (which are the focus of the majority of training/certification programs). Both the OCR guidance and the NHeLP review are quite explicit about minimum requirements for individuals providing services in health care settings. The OCR guidance perhaps errs in assuming that a nurse who speaks both English and Spanish proficiently will be sufficiently familiar with medical terminology to convey the medical meaning and importance of what is being communicated to the person with LEP. The true level of bilingual proficiency should always be formally assessed, and one should not assume that conversational proficiency includes knowledge of medical concepts or terminology in the non-English language. Additionally, on some occasions, bilingual nurses or other non-physician staff will be functioning as interpreters (rather than communicating directly with a patient), and this requires an understanding of how to interpret completely and accurately without condensing, omitting, or distorting the patient-provider communication.

If telephone interpretation is used, providers should have standards by which they evaluate the quality of the services received, and have criteria that they use to select high quality vendors. They should evaluate the recruitment and training programs used to select and train phone interpreters. If phone interpreters are used very frequently, procedures and policies should be in place to facilitate the use of these phone lines, staff should be trained in their use. As noted in the discussion of standard #6 above, both the OCR guidance and the NHeLP review speak to using telephone interpreter services as a supplemental system, as such services may not always have readily available interpreters who are familiar with medical terminology or concepts. Still, telephone interpretation may be the only option in facilities that are very decentralized (such as IPP network), or must deal with large (25 or more) languages, for which it would be difficult to maintain an adequate staff. In general, face to face encounters between patients and clinicians that involve diagnosis, treatment and education may benefit from an on-site interpreter (and if lengthy, be significantly cheaper than using a phone service). Telephone interpretation may be appropriate for non-clinical interactions, emergent situations when waiting for an in-person interpreter may compromise patient outcomes, or situations requiring very uncommon languages.

It is difficult to discuss interpreter/bilingual competence due to the lack of standardized or nationally accepted assessment tools or training programs for medical interpreters or bilingual staff (see Appendix 6 for a detailed discussion on current issues and practices related to medical interpreter training, standards and professionalization, and working with bilingual staff). Excellent examples of each of these have been developed by a variety of medical interpreter experts around the country; however information about them is poorly disseminated. This situation may begin to remedy itself with the formation of the National Council of Interpretation in Health Care (NCIHC) which, at its organizing meeting in May 1998, formally endorsed the Medical Interpreter Standards of Practice developed by the Massachusetts Medical Interpreter Association. The MMIA is also completing work on a certification process for medical interpreters which will similarly be reviewed and potentially endorsed by the NCIHC.

Using the model materials noted in the Appendix 6 providers should endeavor to test and, if necessary, train bilingual staff and interpreters to assure their bilingual proficiency and interpreter skills. Some large health care institutions offer these services in-house; others collaborate with or refer to programs at local colleges or community organizations. However, while assessment processes can often be implemented with existing resources, training programs can be more difficult to initiate if qualified trainers are not available locally. In this case, it is often advantageous for several institutions to pool resources and collaboratively establish a local training program. This structure can also be expanded in time to house a community-based pool of interpreters that could be shared and deployed among many provider organizations.

Providers and policymakers should fund and support the development and adoption of national standards for health care interpreting, training, and skills assessment, including consensus-based role definitions, practice standards, standardized curriculum elements, and standardized competency assessments, especially for small language groups. Support for professional development activities for interpreters (such as the state interpreter associations and the National Council) would speed up this process. In the meantime, policymakers and accreditation agencies should require providers to assure that bilingual staff and interpreters have the appropriate skills and training, using currently available materials and practice standards, and should assist with the dissemination of these resources.

Policymakers and advocates should build awareness among health/social service professional organizations, provider organizations, and policymakers about the relationship between quality health care and clearly defined interpreter roles, responsibilities, and competency. Advocates should educate providers about the availability of interpreter training materials, tests, and standards, as they become available. They should investigate and monitor the quality of interpreter services at health care institutions, and educate communities about the right to a free, qualified interpreter and about the dangers of using unqualified family or friends. Community organizations and funders should also support the development of local training programs for bilingual staff and interpreters.

10. Health care organizations should ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's information management system as well as any patient records used by provider staff.

Document Analysis:

Requirements for assessing patient language needs range from having the appropriate government agency collect and supply information to providers (1 document), to provider responsibility for assessment (6 documents) at key points of contact (1 document). Specific directives include demonstration of patient need and identification of language spoken at home by the patient. Massachusetts requires the reporting of results of needs assessment and utilization of linguistic services by race, ethnicity, and language. One standard requires that providers explain how they will monitor the language preferences of members, and another requires a

system for tracking LEP individuals and the cultural needs of clients. HEDIS 3.0 has specific requirements for data collection on health plan enrollees: the number and percentage of Medicaid members enrolled at any time during the year by race/ethnicity, Hispanic origin, and spoken language. It provides instructions on only using data provided by the state collected at the time of Medicaid eligibility determination. It does not require plans to collect/report this information on their own, and acknowledges that some states may not furnish this information. JCAHO standards speak to need for collecting information on patient and family characteristics, such as beliefs, values, literacy, language, ethnicity, and cultural and family issues.

Discussion:

Collection of race and ethnicity data about clients is perceived as a difficult issue for many providers, policymakers, and accrediting agencies. Confusion abounds as to whether the collection of these data should be mandatory, voluntary, or even permissible (officials at CMMS have recently clarified that collection of these data is permissible, as long as it is voluntary for clients to provide information). While collection of race and ethnicity data may continue to be problematic due to concerns about discrimination, queries about ethnicity or language preference could be posed as a functional issue, i.e., necessary for providers to know in order to provide interpreter/bilingual services, or to plan for dietary or other cultural practices or preferences.

Key issues for collecting information about patient language/ethnicity include: (1) who collects the data; at what points; (2) how are the data collected, recorded, and used? Ideally, for programs requiring enrollment (i.e. managed care programs), the entity responsible for enrollment could collect these data at the time of enrollment, and then pass the information to the provider. This information could be verified at the first point of contact. Other providers could collect and record this information at the first point of contact. The information could be recorded not only in the patient record but also communicated to other departments that might have contact with the patient, such as billing or member services. One hospital in Seattle that uses a computer system for patient information and appointment scheduling has a non-optional field for querying the patient about primary language at the initial intake, and forwards this information automatically to the appropriate clinical department and the interpreter services department for each appointment. An interpreter is automatically scheduled unless a subsequent evaluation reveals that interpreter services are not needed.

Without the collection of this data and its subsequent availability for analysis, it will be impossible to adequately plan for CLAS services for diverse population, verify the utilization of those services, and link service utilization to a variety of outcomes measures. Policymakers, patient advocates and providers need to work together to increase awareness about the need for CLAS-related data collection and to develop policies and systems that will facilitate this process.

11. Health care organizations should use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

Document Analysis:

Seven documents require providers to assess various factors related to the size and characteristics of the actual or potential beneficiary population with respect to the need for language access services. These include: reporting the size of population served and descriptions of beneficiary population demographic profile; a group needs assessment that identifies linguistic and cultural needs using both qualitative and quantitative methods; an analysis of LEP groups by zip code, including those who need interpreters, and the number of zip codes

where a large percentage of residents are LEP. The Colorado contract states that the "contractor shall make a reasonable effort" to determine the number of LEP individuals through data analysis of enrollment and assessments of language proficiency.

Under the category of cultural competence, six source documents require the collection of general ethnic data including: descriptions of geographic, demographic, socioeconomic status and languages spoken in community; description of population densities, ecological factors, and cultural needs; as well as analysis of cultural needs, health practices and behaviors of ethnic groups. Four source documents specifically required the development of a database on ethnic/cultural needs of patients. Language used in these documents address documentation of requests for culture-specific services; data development of utilization trends and services in preferred languages; and documentation that all hospital data are analyzed by race and ethnicity. An October 1997 policy letter from the Secretary of DHHS clarifies that the Department's data collection systems should include race and ethnicity data for all programs.

Discussion:

In order to fully understand current and potential client populations, providers should engage in ongoing development of community profiles and needs assessments. These tools can help providers and policymakers develop appropriate services, and assess access to, and utilization of services. At the most basic level, most requirements for this standard include constructing basic demographic profiles of the providers' service area, including race, ethnicity, and language data. These data can be collected from a variety of sources, including state agencies and census or marketing agencies. It is important to broaden these profiles beyond data collected from enrollment or utilization sources, as these may provide an incomplete portrait of the potential client population (many of whom may not be aware of, or use the provider's services). A more useful and in depth approach would include using a variety of quantitative and qualitative methods to determine cultural factors related to client needs, attitudes, behaviors, and concerns about utilizing health care services. This could include focus groups, interviews, surveys, and epidemiological profiles. These data could be useful for customizing services, as well as enhancing specific or general assessments of quality and outcomes. Epidemiological information about the surrounding community could assist health care organizations to plan for and implement population-based interventions and health education campaigns.

Cataloguing the cultural needs, resources, and assets of an organization's surrounding community can lead to information useful to plan and implement services and linkages with community-based ethnic organizations and private providers who can assist with outreach and service delivery to different ethnic groups.

12. Health care organizations should undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

Document Analysis:

Ten documents address requirements for evaluating linguistic services, and all specifically mention use of patient satisfaction surveys as a means of evaluating satisfaction with services. Two documents call for achievement of target satisfaction rates. California requires Medi-Cal managed care contractors to describe the types of reports or specific studies utilized in monitoring linguistic services and to describe what indicators are considered important in measuring the role of linguistic services in improving access and health outcomes. California state law requires state agencies to survey local offices every two years to determine the number of bilingual staff and the number of LEP persons served, and the Massachusetts guidelines for

hospital quality require providers to collect data and analyze clinical outcomes and patient satisfaction stratified by race and ethnicity and English and Spanish. Hawaii's managed care rules describe the main measure of effective cultural/linguistic services as "recipient satisfaction with services received."

Seven source documents address the need for conducting evaluations of services for diverse populations: Cultural Competence Mental Health Services Plan Requirements, California; Cultural Competence Standards, SAMHSA; California Medi-Cal Managed Care Local Initiative; Medicaid managed care contract language, Colorado; Medicaid managed care contract language, Nebraska; Office of Health and Human Services, Division of Medical Assistance, Massachusetts; and Cultural Competence Organizational Self-Assessment, Massachusetts. Source documents called for culture-specific outcome measures; a description of how quality of service is monitored and documentation of at least 90 percent consumer satisfaction with services; and the development of patient satisfaction surveys that measure cultural competent service delivery.

Six source documents discuss the need for conducting institutional self audits or organizational assessments of cultural competence: Cultural Competence Mental Health Services Plan Requirements, California; Cultural Competence Standards, SAMHSA; California Medi-Cal Managed Care Local Initiative; Medicaid managed care contract language, Massachusetts; and Office of Health and Human Services, Division of Medical Assistance, Massachusetts. Language culled from these source documents address the need for organizational and service assessments, including identification of gaps and needs in current service delivery; demonstration of periodic assessments and cultural competence evaluation; and evidence to improve cultural competence through self-assessment instruments.

Discussion:

Ongoing organizational self examination is essential for planning, implementing and evaluating the quality of any kind of service. In the area of cultural and linguistic competence, many organizations are still largely unaware of the institutional and attitudinal factors that create barriers for diverse populations. In order to provide appropriate services, and demonstrate the effectiveness of those services to themselves and to oversight agencies, health care organizations should conduct an initial assessment of cultural competence and institute ongoing evaluation processes of both the CLAS services, and the impact of those services on patient health outcomes. As with the assessment of individual cultural competence, there has been extensive development of organizational cultural competence assessment tools and cataloging of these tools (see Appendix 6, section 1.7.2).

There are two types of service evaluation with respect to provision of linguistic services. Providers could assess patient satisfaction with the linguistic services, or they could assess variations in utilization, satisfaction, and compliance between LEP patients who receive linguistic services and those who should not. Given the lack of standardization in the delivery of linguistic services, the latter kind of evaluation would appear to be particularly critical, especially at the time of instituting the services or expanding them to include new linguistic and cultural groups. It should be noted that even though patient satisfaction surveys were the most frequently mentioned method of interpreter service evaluation, this approach may not yield a true picture of the quality of services. Research shows that patient satisfaction surveys are particularly difficult to design to capture the patient's complete view of quality and satisfaction, and that cultural variations abound in how clients respond, especially with critical feedback. Also, neither patients nor physicians may truly be able to assess the quality of the services, as there is no completely accurate way for them to verify the competency or accuracy of the interpreter.

Providers and policymakers should support the development of accurate measures of the quality of, and satisfaction with CLAS services and systems. Providers should institute systems to collect

basic data about ethnic clients and CLAS services utilization, and should systematically and regularly examine the quality of services as well as their impact on performance and outcomes.

Providers may also want to consider looking at the potential link between employee satisfaction and patient satisfaction, perhaps as part of the organizational self assessment. Harvard Pilgrim Health Care regularly assesses staff satisfaction to determine whether diverse employees think the organization fosters a positive work environment.

Policymakers should require these evaluation activities of providers, and use the results in ongoing oversight activities.

13. Health care organizations should develop structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

Document Analysis:

Six source documents require institutional policies and procedures to address complaints by patients about unfair treatment. These documents generally called for the formalization of the grievance process. Sample language call for descriptions of the process and documentation of consumer awareness of the process; and written policies and procedures on how to register complaints or file grievances, and mechanisms to resolve grievances about services. Incidentally, several Medicaid contracts explicitly require interpretation and translation services for patients involved in grievance processes, but say nothing about their availability for health care services. Perhaps more of the latter would eliminate the need for the former.

Although none of the documents refers specifically to policies and procedures to address complaints by staff about unfair treatment, JCAHO has a standard that requires hospitals to respect staff requests not to participate in aspects of patient care that might conflict with their cultural values or religious beliefs.

JCAHO also declares as part of its patient rights standards that policies and procedures should reflect a specific populations' needs to address ethical issues. They use the example of a hospital serving a native American population having policies and procedures based on American Indian law and customs.

Discussion:

Formal institutional policies and procedures to address complaints by patients about unfair or discriminatory treatment would provide direction for staff in their efforts to achieve cultural competence. Staff may be instructed in their training classes on how to address patient complaints, with special instruction in the cultural issues that influence patient dissatisfaction. Organizations may also want (or be required) to create programs with an ombudsperson and an ethnically diverse staff to proactively address patients rights and protections. Such a program can also provide a quality feedback loop to the organization on the effectiveness of ongoing cultural and linguistic competency initiatives.

There have been an increasing number of cases of health care facility staff experiencing or perceiving discrimination due to misunderstandings about ethnic, language and cultural differences, and many of these incidents can be quite costly for institutions to resolve. Certainly, organizations should examine and correct any existing policies that might be discriminatory, such as restrictions on foreign language use or religious clothing. Policies and procedures to address complaints by staff about unfair, culturally insensitive or discriminatory treatment can be an

extension of existing policies and procedures (usually maintained by the office of human resources) to address staff complaints about problems in the workplace. Again, staff in these offices should receive additional training on cross cultural issues, and may find that an early and appropriate intervention can defuse difficult situations before they become formal complaints.

Organizations should also examine their policies and procedures that deal with ethical and legal conflicts in health care delivery. Again, cross-cultural training should be provided to staff, and they can be called upon to assist in creative ways to resolve conflicts. One hospital in the Midwest was providing health care to a community of recent immigrants who would not sign informed consent forms because of cultural and religious issues about discussing death and dying. The hospital's legal staff convened a community meeting to search for a compromise position that would meet the community's and hospital's needs. While the perfect solution was never achieved, the dialogue contributed to better relationships and understanding between patients and staff.

14. Health care organizations should report annually in a publication available to the public on how the organization is implementing CLAS standards, including information on programs, staffing, and resources.

Document analysis:

This requirement did not appear in any of the source documents, but was recommended and approved by the advisory committee.

Discussion:

This requirement addresses accountability of health care organizations to their patients and communities. Such a document would be to the organization's benefit because it could be used to reach out to potential clients and to educate providers and staff about the cultural competence goals of the organization. The community would also benefit from such a document because it could allow community residents to understand and monitor the progress their providers are making towards the goal of cultural competence. Ideally it should contain the kinds of information that allows for true community accountability and informed consumer choice, such as the demographics of the patient population; statistics related to interpreter use and availability, translated materials, and staff training; and financial reports on CLAS-related expenditures. Harvard Pilgrim Health Care is one example of a health plan that publishes a regular "Diversity Report" that reviews in a qualitative narrative the goals and progress of the organization related to serving diverse populations.

Bibliography

_____. Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights and [Confidential]. U.S. Department of Health and Human Services, Region X, Seattle, WA, 1981.

_____. Compliance Review of [Confidential]: Statement of Findings. U.S. Department of Health and Human Services, Region X, Seattle, WA, 1980.

_____. Draft LEP Regulation, 45 CFR Part 80, August 1993, U.S. Department of Health and Human Services, Office of the Secretary.

_____. Voluntary Compliance Agreement by the U.S. Department of Health and Human Services and [Confidential] Department of Health and Social Services. U.S. Department of Health and Human Services, Region X, Seattle, WA, 1989.

Alexander, Matthew 1995. Cinemeducation: An Innovative Approach to Teaching Multi-Cultural Diversity in Medicine. *Annals of Behavioral Science and Medical Education*, Vol 2(1): 23-28.

AAPCHO. State Medicaid Managed Care: Requirements for Linguistically Appropriate Health Care, Oakland: Association of Asian Pacific Community Health Organizations, 1996.

ASTHO. ASTHO Bilingual Initiative--Report and Recommendations: State Health Agency Strategies to Develop Linguistically Relevant Public Health Systems. Washington, DC: Association of State and Territorial Health Officials, 1992

Barringer, Felicity 1993. For 32 Million Americans, English is a 2nd Language. *New York Times*, Wednesday, April 28, 1993.

Berlin, E. Fowkes, W. A Teaching Framework for Cross-Cultural Health Care. *The Western Journal of Medicine*. December 1983; 139:6, 934-38.

Blackhall, Leslie J., Sheila T. Murphy, Gelya Frank, Vicki Michel and Stanley Azen 1995. Ethnicity and Attitudes Toward Patient Autonomy. *Journal of American Medical Association*, Vol 274(10):820-825.

California Cultural Competency Task Force. Recommendations for the Medi-Cal Managed Care Program. Berkeley, CA: Institute for the Study of Social Change, 1994.

The Chicago Institute on Urban Poverty. Impacts of Medicaid Managed Care on Immigrants and Refugees: A Best Practices Review with Policy Recommendations. Chicago: Heartland Alliance for Human Needs and Human Rights, 1996.

Commonwealth of Massachusetts. House Bill 2498: An Act to Create a Bureau of Interpreter Services within the Executive Office of Administration and Finance et seq. Boston: House of Representatives, Massachusetts State Legislature, 1989.

Coye, Molly and Deborah Alvarez. *Medicaid Managed Care and Cultural Diversity in California*. The Commonwealth Fund, March 1999.

Cross, Terry L., Barbara J. Bazron, Karl W. Dennis and Mareasa R. Issacs 1989. *Towards A Culturally Competent System of Care*, Vol I. Washington DC: The Georgetown University Child Development Center.

Cummins, J. 1986. Psychological Assessment of Minority Students. In Willig, A.C. and Greenberg, H.F. eds. *Bilingualism and Learning Disabilities: Policy and Practice for Teachers and Administrators*, pp 3-14. New York: American Library Publishing.

Deutsch, Claudia 1996. Corporate Diversity, In Practice: Networks Are Created and Managers Made Accountable. *New York Times*, November 20.

DiBella, Anthony 1991. The Role of Assumptions in Implementing Management Practices Across Cultural Boundaries. *Journal of Applied Behavioral Science*, Vol 29(3):311-327.

Diversity Rx (www.DiversityRx.org), an electronic clearinghouse of information about language and culture in health care. Washington, DC: National Conference of State Legislatures and Resources for Cross Cultural Health Care, May 1997 and ongoing.

Downing, Bruce, "Professional Interpretation: Insuring Access for Refugee and Immigrant Patients." Presentation to the National Conference on Health and Mental Health of Soviet Refugees. December 10, 1991.

Estrada, Armando, personal communication, April 1999.

Fitzgerald, K.W. Testimony Regarding HB 2498 to the Joint Committee on State Administration, Boston: Commonwealth of Massachusetts, 1989.

Fortier, Julia Puebla and Francis Chang, eds. "The Henry J. Kaiser Foundation Forum: Language Barriers to Health Care." *Journal of Health Care for the Poor and Underserved*. Vol. 9, Supplemental 1998

Fortier, Julia Puebla. *Multicultural Health Best Practices Overview for The California Endowment Multicultural Health Investment Area*. Resources for Cross Cultural Health Care and The California Endowment, February, 1998.

Fortier, Julia Puebla. "Interpreting for Health in the United States: Government Partnerships with Communities, Interpreters, and Providers," in *The Critical Link: Interpreters in the Community*. Philadelphia: John Benjamins Press, 1997.

Ginsberg, Caren, Vanessa Martin, Dennis Andrulis, Yoku Shaw-Taylor and Carla McGregor. *Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals*. Washington DC: National Public Health and Hospital Institute, March 1995.

Gonzalez, Virginia M., Judith T. Gonzalez, Victor Freeman, and Beth Howard-Pitney 1991. *Health Promotion in Diverse Cultural Communities: Practical Guidelines for Working in and with Diverse Cultural Communities*. Palo Alto, CA: Stanford Center for Research in Disease Prevention.

HR Explanation and Advice 1997. *Diversity Management*. Alexandria, VA: Research Institute of America, Inc.

Human Resources Management 1994. Getting the Most Out of Talented but Diverse Individuals. Reprinted from *Ideas and Trends in Personnel Newsletter*. Chicago: CCH Inc.

Immigrant Refugee Task Force and Lucas, P. Policy Memo for Health Providers. Travellers & Immigrants Aid, Chicago, IL.

Immigrant Refugee Task Force. Policy Platform: For Improved Health Care Services to Immigrants and Refugees in Public and Private Health Agencies and Organizations. Travellers & Immigrants Aid, Chicago, IL.

Issacs, Mareasa R. and Marva P. Benjamin 1991. *Towards A Culturally Competent System of Care, Vol II*. Washington DC: The Georgetown University Child Development Center.

Jecker, Nancy S. Joseph A. Carrese and Robert A. Pearlman 1995. Caring for Patients in Cross-Cultural Settings. *Hastings Center Report*, (Jan/Feb) 1995:6-13.

Karp, H.B. and Nancy Sutton 1993. Where Diversity Training Goes Wrong. *Training*, July: 30-34.

Katz, Michael, personal communication, November 1998.

Klein, Amy, et al. *Background paper for the national assessment of linguistically and culturally appropriate services in managed care organizations serving diverse and vulnerable populations*. Washington, DC: Mathematica Policy Research, January 1998.

Lavizzo-Mourey, Risa, and E.R. MacKenzie, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," *Annals of Internal Medicine* 124 (10):919-921.

Leonard, Bill 1991. Ways to Make Diversity Programs Work. *HR Magazine*, April:37-39.

Levine, David M., Diane M. Becker, Lee R. Bone, Martha N. Hill, Melvin Tuggle II, and Scott Zeger 1994. Community-Academic Health Center Partnerships for Underserved Minority Populations. *Journal of American Medical Association*, Vol 272(4):309-311.

Like, Robert C. R. Prasaad Steiner and Arthur Rubel 1996. Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care. *Family Medicine*, Vol 8(4):291-297.

Lipson, Juliene G., Suzanne L. Dibble and Pamela A. Minarik (eds) 1996. *Culture and Nursing Care: A Pocket Guide*. San Francisco: University of California San Francisco Nursing Press.

Louis Harris and Associates. National Comparative Survey of Minority Health Care. New York: The Commonwealth Fund, March 1995

Metzger, R. Winter. Hispanics, Health Care, and Title VI of the Civil Rights Act of 1964. *The Kansas Journal of Law and Public Policy*, 1993-4; 31-42.

Mitchell, Russell 1994. Managing By Values: Is Levi Strauss Approach Visionary or Flaky? *Business Week*, August 1:46-52.

Muller, Helen and Barbara Haase 1994. Managing Diversity in Health Service Organizations. *Hospital and Health Services Administration*, Vol 39(4):415-434.

Murawski, J. Hispanic Woman Charges Clinic with 'Assault.' *Legal Times* (Washington, DC) 1993, May 24; 1.

NACHO. National Association of County Health Officials Multicultural Health Project--Recommendations and Case Study Reports. Washington, DC: National Association of County Health Officials, 1992.

Pachter, Lee M. 1994. Culture and Clinical Care: Folk Illness Beliefs and Behaviors and Their Implications for Health Care Delivery. *Journal of American Medical Association*, Vol 271(9):690-694.

Perkins, Jane, et al. *Ensuring Linguistic Access in Health Care Settings*. Palo Alto: The Henry J. Kaiser Family Foundation, April, 1998.

Personal communications, Carmen P. Rockwell, Office for Civil Rights, Region X, HHS, Seattle, WA, 1991-93.

Project Hope. Medicaid Managed Care Program Access Requirements. Washington, DC: Prospective Payment Assessment Commission, 1995.

Raher, P. Legal Petition on Behalf of League of United American Citizens, et al, to the Honorable Joseph A. Califano, Secretary, US Department of Health, Education, and Welfare. 1978, Law Firm of Hogan & Hartson, Washington, DC.

Raher, P. Letter and Proposed HEW Bilingual Regulations. 1980, Law Firm of Hogan & Hartson, Washington, DC.

Randall-David, Elizabeth 1989. *Strategies for Working with Culturally Diverse Communities and Clients*. Washington DC: Department of Health and Human Services.

Richman, R. Failure to Communicate. *The Chicago Reporter* 1993, March; 22(3):1, 6-11.

Riess, J. and Riddick, S. Influencing Hospitals to Hire Bilingual Staff: Economic Carrots and Legal Sticks. Presented at the American Public Health Association Annual Meeting, November 1982; Montreal, Canada.

Roizner, M. A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations. Boston: Judge Baker's Children's Center, 1996.

Rossett, Allison and Terry Bickham 1994. Diversity Training: Hope, Faith and Cynicism. *Training*, January:41-46.

Schimpff, Stephen C. Morton I. Rapoport, Sharon L. O'Keefe, Dennis A. Grote and Lisa Keefe Snow 1996. The University of Maryland Medical System Invests in Its Community's Minorities. *Academic Medicine*, Vol 71(6):604-612.

Schmidt, R.E. et al. Limited English Proficiency as a Barrier to Health and Social Services. Washington, D.C.:HHS Office for Civil Rights, 1995.

Sherer, Jill 1993. New Waves: Hospitals Struggle to Meet the Challenge of Multiculturalism Now - and in the Next Generation. *Hospitals*, May 20: 22-31.

Stehno, S.M. 1982. Differential Treatment of Minority Children in Service Systems. *Social Work*, Vol 27(1):39-46.

State of Illinois. Public Act 88-244, "The Language Assistance Services Act." Springfield: General Assembly of the State of Illinois, 1993.

State of California. Cultural and Linguistic Requirements Subgroup: Recommended Standards for the Medi-Cal Managed Care Program. Sacramento: State of California Department of Health Services, 1993.

State of California. Letter requesting applications for the Cultural and Linguistics Standards Task Force. Sacramento: State of California Department of Health Services, 1995.

State of California. Request for Applications for Medi-Cal Managed Care Contractors. Sacramento: State of California Department of Health Services, 1994.

Svehla, Trisha and Glen Crosier 1994. *Managing the Mosaic: Addressing Workforce Diversity and Managing Institutional Change in Health Care*. Chicago: American Hospital Publishing.

Tenorio, S.C. Testimony on HB 2498: Bureau of Interpreter Services Availability and Access to the Public Administration Committee, Boston: Commonwealth of Massachusetts, 1989.

Thorngren, M. Proyecto Informar, National Coalition for Hispanic Health and Human Services Organization, Washington, DC, Unpublished manuscript, 1993.

Travellers & Immigrants Aid. Fact Sheet: The Rights of Immigrants to Language Assistance when Seeking Health and Human Services. Chicago: Travellers & Immigrants Aid, 1994.

Trosty, R. Stephen, presentation at the Quality Health Care for Culturally Diverse Populations conference, New York, October 1-4, 1998.

USCLHO and USCM. Language and Culture in Health Care: Coping with Linguistic and Cultural Differences: Challenges to Local Health Departments. Washington, DC: United States Conference of Local Health Officers and United States Conference of Mayors, 1993.

U.S. House of Representatives Committee on Energy and Commerce. Report 103-501 accompanying H.R. 3869, Minority Health Improvement Act of 1994, May 11, 1994.

U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health and the Environment, Hearing on reauthorization of expiring minority health and disadvantaged student health professions programs, June 9, 1993.

U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health and the Environment, Hearing on health status and needs on minorities in the U.S., June 8, 1990.

U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health and the Environment. Discussion draft of minority health legislation, December 1993.

U.S. House of Representatives. Conference report 103-843 accompanying S. 1569, Minority Health Improvement Act of 1994, October 6, 1994.

U.S. House of Representatives Report 101-804, to accompany H.R. 5702, the Disadvantaged Minority Health Improvement Act of 1990, 28-29, 47-48.

U.S. Senate, S. 1757, Health Security Act of 1993, November 22, 1993, §1402(c) pp. 227-8; 3424(e), pp.592; and §3461, pp. 605-608.

U.S. House of Representatives Report 101-804, to accompany H.R. 5702, the Disadvantaged Minority Health Improvement Act of 1990, 28-29, 47-48.

Veith, Betsy and Edward Boone III 1996. *Cultural Competency in Health Care: A Snapshot of Current Issues*. Washington, DC: Opening Doors.

Voelker, Rebecca 1995. Speaking the Languages of Medicine and Culture. *Journal of American Medical Association*, Vol 273(21):1639-1641.

Wagner, Mary 1991. Managing Diversity. *Modern Healthcare*, September: 24-29.

Walker, Patricia 1994. Delivering Culturally Competent Care in a Multicultural Society: Challenges for Physicians. *HCMS Bulletin*, (July/August) 1994:8-10.

Washington State Department of Social and Health Services. Language Interpreter Services and Translations: Bilingual Orientation Packet. Washington State Department of Social and Health Services, Olympia, WA.

Woloshin, Steven , Nina A. Bickell, Lisa Schwartz, Francesca Gany and H. Gilbert Welch 1995. Language Barriers in Medicine in the United States. *Journal of American Medical Association*, Vol 273(9):724-728.

Appendix 1: Source Document Master List

Thirty source documents were reviewed and analyzed for language on linguistic and cultural competence standards or measures. Twenty of these documents were accessed from the National Health Law Program's (NHeLP) 1998 publication, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, and included all Medicaid managed care contract language and the summaries of state law requirements addressing language and cultural needs from ten regionally representative states. We also conducted a separate review of the original contracts selected for inclusion, which are on file in the NHeLP-North Carolina office. Medicaid managed care language was also partly culled from the Center for Health Policy Research's 1997 publication, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*. The document entitled "The Office of Civil Rights' 'Bottom Lines' for Linguistic Accessibility" is based on NHeLP's review and summary of more than 100 compliance agreements or communications from the HHS Office for Civil Rights to providers who are recipients of federal funds. The Consumer Bill of Rights, contained in *Quality First: Better Health Care for All Americans. Final Report to the President of the United States* from The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, has been adopted as policy guidance for all Federal health care programs.

The source documents are as follows:

(1) Department of Health and Human Services, Office of Civil Rights. *Guidance Memorandum: Title VI Prohibition Against National Origin Discrimination-Persons with Limited-English Proficiency (1998)*.

(2) State of California, Health Welfare Agency, Department of Mental Health. *Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services-Cultural Competence Plan Requirements(1997)*.

(3) New York State, Office of Mental Health. *Cultural and Linguistic Competency Standards (1997)*.

(4) Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups (1997)*.

(5) California Department of Health Services. *Medi-Cal Managed Care Local Initiative/Medi-Cal Managed Care Requirements Evaluation of Cultural and Linguistic Requirements*.

(6) National Committee on Quality Assurance. *Availability of Language Interpretation Services/Summary of Changes from HEDIS 2.5 and/or Medicaid HEDIS, 3.0, Volume 2* (1997).

(7) National Health Law Program. *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, "Office of Civil Right's Bottom Lines for Linguistic Accessibility," 1998.

Medicaid managed care contract language for

(8) California; (9) Colorado; (10) Florida; (11) Hawaii; (12) Massachusetts; (13) Nebraska; (14) Pennsylvania; (15) Texas; (16) Vermont; (17) Washington.

Summary of state law requirements addressing language and cultural needs for

(18) California; (19) Colorado; (20) Hawaii; (21) Massachusetts; (22) Florida; (23) Pennsylvania; (24) Texas; (25) Vermont; (26) Washington.

(27) The Commonwealth of Massachusetts, Division of Medical Assistance. *Contract Requirements for Cultural Competence* (1997)

(28) Joint Commission on Accreditation of Health Care Organizations' *Comprehensive Accreditation Manuals for: Ambulatory Care, Behavioral Health Care, Health Care Networks, Home Care, Hospitals, and Long Term Care* (selections).

(29) The Consumer Bill of Rights, contained in *Quality First: Better Health Care for All Americans. Final Report to the President of the United States*. The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997

(30) Medicare+Choice regulations