



California Pan-Ethnic Health Network

Practical Approaches to Cultural Competency: Working for Equality in Health

Statewide Conference Summary

**September 27, 2005
Preservation Park, Oakland**

Introduction

The California Pan-Ethnic Health Network hosted its first statewide conference, Practical Approaches to Cultural Competency: Working for Equality in Health on Tuesday, September 27, 2005. Held at Preservation Park in Oakland, California, the convening provided an opportunity to share emerging frameworks and create dialogue among diverse health professionals on ways to integrate cultural competency into their health care practice. Approximately 175 participants attended.

Keynote Address

Ignatius Bau, Senior Program Officer, The California Endowment

Ignatius Bau, Program Officer with The California Endowment (TCE), began the day by sharing TCE's current funding priorities: access to health, culturally competent health care systems, and community health and elimination of disparities. He then elaborated on TCE's proposed framework for culturally competent health systems. This framework is based on recommendations from Institute of Medicine Reports. These recommendations include ensuring patient safety, improving quality, reducing health disparities, and diversifying the health workforce. TCE's framework is also based on goals established by the Healthy People 2010 objectives to increase quality and years of life and eliminate health disparities.

According to Bau's presentation, culturally competent health systems engage with and respond to diverse individuals and communities. TCE's goal is to move health systems in California to become culturally competent. In order to achieve this goal, TCE needs to implement policies and best practices that support culturally and linguistically appropriate health services. They need to increase the racial and ethnic diversity of the health workforce and improve the geographic distribution of health providers, particularly in rural and underserved areas. Strategies to achieve this goal are: policy change, education and training of health professionals, quality improvements in health systems, plans and providers, and engagement of patients and/or consumers. Bau continued his presentation by elaborating on three components of TCE's framework: diverse health workforce serving the underserved, equal access regardless of language, and health care services tailored and effective for diverse populations.

Panel One

Creative Solutions for Health Equity

- **Facilitator: Beatriz Solis**, CPEHN Board of Directors
- **Richard Figueroa**, Legislative Director, California Insurance Commissioner John Garamendi
- **Karen Graham**, Health Plan Manager, Marriott International
- **Preston J. Maring**, MD, Associate Physician-in-Chief, Kaiser Permanente Medical Center, Oakland
- **Monica Valdez Lupi**, Chief of Staff, Boston Public Health Commission
- **Cindy Young**, Senior Member Benefits Coordinator, California School Employees Association, Member of California Health Care Coalition

Beatriz Solis facilitated the first panel of the day. She began the discussion by referring to the current political climate in the aftermath of Hurricane Katrina, and asking the panel the following two questions:

- How do we talk about race when we discuss the health of constituents and employees that are diverse?
- How do you begin to discuss the issue of race when we live in a society where it is not acknowledged as an issue?

Each panelist responded to these questions:

- Karen Graham from Marriott International referred to her organization's biggest difficulty related to race; they cannot share ethnicity or race codes with health plans, which makes the development of best practices difficult.
- Preston Maring from the Kaiser Permanente Medical Center in Oakland discussed the fact that the conversation about race and ethnicity starts from the first day of employment at the medical center. New employees are told that the medical center is a complicated, urban teaching facility that sits in the second most diverse city in America. They are told that this presents not just a challenge but also a complex richness.
- Cindy Young from the California School Employees Association stated that her association represents 225,000 classified employees in the school system statewide. 100,000 do not qualify for employer coverage and 40% of those are people of color. At one school district in Palo Alto, the premium for health insurance exceeds employee wages. Her association is concerned with these numbers as well as the quality of care for classified employees. She noted that administrative and medical data identified providers that provide superior care.
- Monica Valdez Lupi of the Boston Public Health Commission stated that in Boston, race is talked about through health outcome data.
- Richard Figueroa, the Legislative Director for California Insurance Commissioner John Garamendi, stated that Katrina is a visual representation of the disparities in our country. He added that the data about health disparities is not in the consciousness of the general population; we need to expand this discussion about cultural competency to a national consciousness.

The facilitator then asked the panelists to further discuss their challenges and how they address them:

- Graham's challenge is working with so many different health plans across the country that do not have the time or consensus to do more than translate materials into Spanish. Vendors need momentum from other employers.
- Figueroa stated that the incremental changes that need to be made (such as finding appropriate curriculums for classes, finding money for translation, etc.) are frustrating. Though we progress every year (this year we made progress with SB853) the steps are incremental.
- Young's challenge is having a standard by which to judge cultural competency in health care. We need measurement tools for outcomes and services.
- Valdez Lupi's challenge is collaboration between all of the different groups working on disparities and educating people about the impact of cultural competency.
- Maring's challenges have been at the level of space and language needs. Fortunately, Kaiser has supported this work at the frontline level, which is good for member health and satisfaction. Therefore, the incentives exist to make cultural competency work.

The audience was then invited to ask questions. Many questions were related to the difficulty of collecting and sharing race and ethnicity data. Most of the panelists mentioned that the collection of this data is important and recommended, but difficult to do. Valdez Lupi stated that registrars are just as reluctant to collect the data as patients are to providing it. However, with the proper sensitivity training and scripts, patients are more likely to share the information because they understand that it is being collected to provide equitable care. Figueroa added that most insurance forms do not have space to collect race or ethnicity data.

Finally, panelists were asked to share successes addressing disparities related to undocumented immigrant status. Figueroa responded by stating that because of the "don't ask, don't tell" policy in programs like CHDP and MediCal, we generally cannot know what our successes are.

The facilitator then asked what existing systems are doing to decrease disparities and increase health. Maring responded by describing the Kaiser Permanente farmer's market program. Thirty farmer's markets are held at Kaiser Permanente facilities all over the country, including the Oakland medical center. A survey of local residents shows that they now have better access to fruit and vegetables and are eating them more than in the past. This project has served as an impetus for other ideas, such as providing cooking classes and supplying hospital facilities (cafeteria, patient foods, conferences) with fresh fruit and vegetables from local farmers. Kaiser's strategy focuses on health care at the most basic level: education about, and access to, fresh food, which can influence the long-term health of populations.

The facilitator's final question was: What is a culturally competent health care system for your constituents?

- Figueroa explained that The Department of Insurance and Managed Health Care has people to answer phones in multiple languages, which is the easy part. The harder part is to impact cultural competency. It is important to back things like SB853 in order to help the population. We have the AT&T Language Line to take patient's complaints about how they have been treated. But, Figueroa asked, what can we do as regulatory, contracting entities to make sure that those who provide services they are doing what they should be doing?
- Young's believes that a culturally competent health care system is one in which everyone has affordable, quality health care regardless of race, etc.
- Graham's version of a culturally competent system involves plans that use evidence-based medicine applied to populations. Employers need to pick plans that work best for their population.
- Valdes Lupi stated that we need to be continually aware of stereotypes and biases. We also need to include consumers in policy decisions.
- Maring asserted that this issue is about distribution of resources and how that changes based on the needs of the population.

Panel Two

Integrating Cultural Competency into Organizational Practice

- **Facilitator: Sunita Mutha**, MD, Center for the Health Professions, University of California, San Francisco
- **Robert Phillips**, Patient Advocate
- **Paula D. Allen**, Traditional Resources Specialist, United Indian Health Services, Inc.
- **Dennis Evans**, Molina Healthcare, Inc.
- **Gamini Gunawardane**, PhD, JD, Director of Legal, Regulatory Affairs and CLAS, Care1st Health Plan
- **Nancy Steiger**, RN, MS, Chief Executive Officer, San Mateo Medical Center

Sunita Mutha facilitated the second panel of the day. The purpose of this panel was to hear about innovative approaches by hospitals, clinics, and health plans to incorporate cultural competency into their facilities and operations to improve their services.

Robert Phillips

Robert Phillips is a patient and a patient advocate. He has been on dialysis for six years. Phillips presentation focused on the fact that the medical field did not do a lot to make him feel comfortable despite the fact that he received first-rate medical care and medical coverage. He often felt isolated and dehumanized; he often felt more like a file than a person. This is devastating to clinical outcomes. When patients talk about outcomes, they refer to the nature of the case; the experience is paramount.

Phillips shared that patients present differently, have different beliefs, and have different thresholds for care that influence how they respond. If providers fail to recognize this, they have non-compliant patients, which makes it harder for providers to do their jobs.

Phillips explains that providers need to have knowledge of the impact of race, ethnicity and other social/cultural differences. Failing to note these differences can result in a hostile working environment. However, cultural competence is only one approach. It is not going to fix all patients' problematic health care experiences. We need providers with the skill to provide care to all patients by acknowledging and responding to patients' beliefs, attitudes, and preferences.

Phillips ended his presentation by outlining principles from a report that AHCOR conducted on patient satisfaction and beliefs. Some of the main qualities patients looked for and appreciated in their providers were: curiosity, exploration, empathy and responsiveness to patients. A provider's ability to address difficult patients is a skill set.

Dr. Gamini Gunawardane

Dr. Gamini Gunawardane presented an overview of the Care 1st Health Plan and highlighted how cultural competency became a priority for the organization. Factors included the highly diverse population of Los Angeles and their companies' belief that quality of care and customer satisfaction depends on both the outcome and the process.

In order to prioritize cultural competency, Care 1st Health Plan had to get ownership from their board, engage medical management, coordinate with human resources, and get contracted medical groups and providers on board. Dr. Gunawardane explained that the health plan's awareness of the importance of cultural competency is one thing, but the actual enactment of culturally competent practices by providers is another. Care 1st Health Plan is a couple of steps removed from the provider.

Care 1st Health Plan has been able to convince their Board to adopt National Culturally and Linguistically Appropriate Services (CLAS) Standards. They found that it was important to first diversify their own staff by using diversity as a factor in their final hiring decisions. They have also been able to provide cultural competency activities and materials for all staff, including mandatory training for new hires, annual seminars, workshops, events, tool kits, and newsletters containing information regarding cultural practices. Moreover, Care 1st has integrated cultural competency into management activities and tested documents for cultural appropriateness. Now staff members are taking pride in promoting cultural competency. Despite these accomplishments, challenges remain. These challenges include: identifying significant and addressable cultural non-competencies, exploring coordinating mechanisms to reach providers, expanding awareness, attitudes, knowledge, and skills at the provider level, and expanding staff further to include other ethnic groups.

Dr. Gunawardane then offered advice for what others can do to implement similar changes. The foremost suggestion offered was to follow a total quality management (TQM) approach.

Dennis Evans

Dennis Evans presented for Martha Bernadett of Molina Healthcare. Molina Healthcare has been in business for twenty-five years and has approximately 900,000 members in six states. The membership is diverse and speaks over seventeen languages, with a primary emphasis on Latino populations. Molina also focuses on Medicaid and low-income populations.

During his presentation, Evans discussed the continuum of care in the context of what works as far as cultural competency at Molina. Evans highlighted two strategies : the Patient Access Coordinator and We Speak Together. The Patient Access Coordinator finds noncompliant members and makes appointments for them. We Speak Together is a program in which Spanish-speaking nurses work from home to provide language access lines for patients. They found that when speaking in their primary language), patients will discuss more than the immediate problem, which helps with diagnosis and prevention. Evans also discussed the ways in which Molina addresses gaps such as language barriers, cultural knowledge gaps and issues of acculturation. They analyze ideal situations and make recommendations such as: language matching, language assistance tools, training and educating staff and community, and developing resource lists.

Paula Allen

Paula Allen presented an overview of the newly created Health Village in Arcata. The Village was developed by a nonprofit health tribal consortium that has 12,000 – 15,000 registered clients and nine member tribes. It was started by a dedicated group of American Indian women whose families had no access to care. The service area for this consortium includes Humboldt and Del Norte counties. In addition to the main site in Arcata, there are smaller satellite services throughout the area.

Allen presented pictures of the new Health Village as she told the story of its development. In planning for the Health Village, architects met with tribal elders as well as providers. The architects asked: what does the community need for wellness? The response was the design for the Health Village. Buildings are modeled after traditional homes. Each department is in a separate house. There is a gathering room where community members are welcomed into the Health Village. Traditionally, each door faces a water source. At the Health Village, each door faces the wellness garden, which is the water source. Artwork and cultural items are on display. The site is on forty acres, twenty of which can be developed. Child and elder care facilities will be built soon. The rest is conservation land. They wanted a place for community members to walk.

The goal was to create a space that recognizes the history of the land and people. The community has experienced great losses of language and culture in the past. They are trying to heal their losses by creating a space for a positive experience, where community members can build relationships with each other and with something bigger than themselves.

As they continue to develop the Health Village, they will be putting policies in place to match these practices and beliefs. Allen ended her presentation by sharing that the community had been isolating themselves and are now experiencing a “coming out.” They are excited to find that people in surrounding communities have similar values.

Nancy Steiger

Nancy Steiger began her presentation with an overview of the San Mateo Medical Center. It is licensed for 509 beds including 345 long-term care beds, which makes it the second largest center in the state for long-term care. Thirteen clinics provide more than 220,000 ambulatory visits, and they experience 32,000 emergency visits annually. More than 50% of their patients are monolingual in a language other than English. These patients speak seventeen different languages, with the majority speaking Spanish.

Steiger shared that cultural competency has been a priority for the Medical Center for a long time because 35% of the population they serve requires interpretation, and because the Medical Center focuses heavily on patient safety and service excellence. They eventually realized that there was a relationship between cultural competence, language access, service excellence and patient safety. They then realized that it was necessary and possible to find funding for this work and that in fact, their budget was a reflection of their values. This year they added more to the budget for cultural competency and language access.

Since establishing cultural competency as a priority, the Medical Center has accomplished the following: increased access to the language line services, participated in a collaborative of public hospitals to create a pool of multilingual interpreters, provided forty hours of training for medical interpreters, and trained emergency department providers on how to access and work more effectively with interpreter services. The emergency department is now better able to treat patients in ways that respect and take into consideration their cultural and linguistic backgrounds. Steiger added that it is important to change how people feel about their care and their role in their care.

To sustain this effort, the Medical Center linked cultural competence to patient safety and service excellence in an effort to promote a culture of safety. To this end, they have built cultural competence into initial orientation, ongoing training, job descriptions, and policies and procedures. They have integrated this cultural competency incrementally to hardwire it into the areas of safety and excellence.

Steiger shared the following advice for someone wanting to replicate this effort: think about how language access and cultural competence fit into the organizational goals and strategies and ensure that it is not viewed as the strategy of the day (meaning, if this is not linked and clearly visible, it is not prioritized); start by recognizing special needs and concerns of clients that have limited English proficiency and/or are members of linguistic and culturally diverse groups; make incremental, small changes using rapid cycle PDSA interventions; involve front line and impacted staff along with managers in the development process; seek support from outside the organization and become involved in collaborative efforts with other institutions; and finally, give it roots and wings.

Audience Questions

Two audience members asked questions following the panel presentations. The first was regarding state requirements for interpreters. The participant commented that her local interpreting agency does not do background checks; this concerned her and she asked for feedback from the panel. Another audience member from the California Healthcare Interpreting Association responded that he is working with NICHQ to develop an on-line registry for interpreters. Paula Allen added that a key strategy for cultural competency that would also address this issue is to employ community-based interpreters.

The other audience question was regarding how organizations are employing people from different cultures to address cultural competency. Gunawardane responded that there is great incentive to have linguistically and culturally competent employees to ensure success. The culture of diversity in the company helps the company and helps patients. Phillips added that the community's role is to help the hospital understand that cultural competency is more than just a gimmick; it is about responding to patients and where and who they are. Steiger stated that according to patient satisfaction surveys, providers need to understand more about things such as room size and feel.

Small Group Discussions

After the panelists finished their presentations, the audience was given three questions to further explore at their tables. Panelists joined the participants in these conversations.

Each table discussed one of the following questions:

1. How do you overcome barriers such as time for training, resistance, and an increase in the length of office visits?
2. How do you convince organizational leaders about the importance of cultural competency and its effect on the bottom line? How do you insure compliance with policies?
3. What are effective strategies for training providers and office staff about cultural competency? How do we demonstrate the effectiveness of these strategies (measurable outcomes)?

In response to the first question, “How do you overcome barriers such as time for training, resistance, and an increase in the length of office visits?” the audience focused on the training component. They reported that we need to:

- Involve providers in training
- Use time in the clinics for training
- Use a multidisciplinary approach
- Train the health plans
- Offer incentives, including monetary compensation, for training
- Provide flexibility in training options (timing – such as training on weekends, and use of technology – such as the Internet)
- Implement sanctions to enforce trainings
- Have health plans train providers to help focus on improving care for members

Responding to the second question, “How do you convince organizational leaders about the importance of cultural competency and its effect on the bottom line? How do you insure compliance with policies?” the audience suggested the following:

- Develop and implement cultural competency organizational assessments
- Implement a bonus structure
- Appeal to leadership through the bottom line: data shows that patient and job satisfaction is related to cultural competency
- Organizations can share positive results of cultural competence work with other leaders to spur competition to get them to do the right thing
- Panelists added that this work needs to be rooted in the organization’s mission and values and in the dignity of people; it has to make sense and spur people to action. It also needs to be integrated into the existing healthcare structure

The third question, “What are effective strategies for training providers and office staff about cultural competency? How do we demonstrate the effectiveness of these strategies (measurable outcomes)?” generated concerns about the concept of cultural competency. One group stated that “cultural competency” assumes that you will someday become competent. Another asked if cultural competency should be discussed in terms of cultural awareness and/or respect. In addition to these questions, participants recommended:

- Training needs to be continuous and include a component on the culture(s) of the community; cannot just be something that you cover during an hour at lunch
- Organizations need to conduct assessments before and after trainings
- We need to monitor disparities with traditional medical outcomes; we should see how consumers treated differently when they come to the door

Panel Three

Increasing Quality Care through Cultural Competency

- Facilitator: **Anne Beal**, MD, MPH, The Commonwealth Fund
- **Leticia Gonzalez**, Health Promoter
- **Nicole Reavis**, MEd, Project Director, National Initiative for Children's Healthcare Quality (NICHQ)
- **Lok Wong**, MHS, Senior Health Care Analyst, Quality Measurement, National Committee for Quality Assurance (NCQA)
- **Amy L. Wilson**, MPP, CPHQ, Associate Project Director, Principle Investigator, Hospitals, Language and Culture, Division of Standards and Survey Methods, Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Anne Beal facilitated the third panel of the day. At the beginning of panel three, it was recognized that we are preaching to the choir and that we are all advocates of cultural competency. This panel addressed issues related to the integration of cultural competency and quality in everything we do.

Leticia Gonzales

Leticia Gonzalez (and her professionally trained translator daughter, Judy) began this panel. Gonzalez spoke about what happened at the hospital when she went there with stomach pain. She noted that no one could tell what ailment she had just by looking at her. No one in the hospital spoke Spanish and eventually they gave her a prescription for Pepto Bismol. Days later, she still felt bad. Approximately one month later, she went to Mexico where the doctors found that she needed a gall bladder operation. Gonzalez explained that this is an example of what can happen when people don't know the language of their patients or of their doctors). There are many people providing services who don't know Spanish.

As a health promoter, Gonzalez explained: You need to know the culture, not just the language. You need to get deep into the values; there are many customs, idiomatic expressions, and words that are different. Gonzalez presented some words and phrases that do not literally translate and discussed the cultural issues that a doctor might not understand. Gonzalez reiterated that competency is more than language; it is about values, beliefs, morals, etc. She emphasized that it is important to know the Mexican culture. To emphasize the importance of this, she related an example of a woman who had an ectopic pregnancy. The next time that she was pregnant, the doctor asked her if she wanted to terminate the pregnancy because she had terminated the ectopic pregnancy; this was highly insulting to her as a Mexican woman. She urged listeners to remember her examples as they are planning to become more culturally competent.

Nicole Reavis

Nicole Reavis from the National Initiative for Children's Healthcare Quality (NICHQ) was the second presenter. She started by discussing other words that some people prefer over competency, including: "effective," "awareness," "proficiency." Reavis said she does not want to minimize the importance of this discussion, but wants to focus on the

work to make competency or proficiency or whatever we call it happen. The mission of NICHQ is to close the gap between what is and what can be for all children.

In her presentation, Reavis provided a project overview. The focus of the project was to integrate quality improvement and cultural competency. The project took place from May 2004 to August 2005 with a focus in California. The objectives were to:

- Create a strategy for improving cultural competency in children's healthcare within a specific framework
- Develop practical strategies that health care organizations – primary practices in particular – can use to become better able to care for diverse populations
- Develop measures that can be used to track progress towards the goal of culturally competent care

Reavis emphasized that measures are essential to the goals of cultural competency. They had core measures focused on the outcome, process, and structure. They also put in place additional measures to balance the findings and to make sure that changes do not yield negative impacts. Regarding outcomes, they measured the magnitude of difference among racial/ethnic groups in key clinical outcomes. This is important when looking at chronic conditions. Regarding process, they measured the percent of patients receiving care in their preferred language and the percent of children and families with race/ethnicity, language preference, and desire for an interpreter identified in the data system or the medical record.

The key findings that resulted from these measurements are that providing trained interpreters, even telephonically, resulted in better communication, more appropriate diagnosis, and a deeper understanding of patient needs. In addition, staff exposure to the cultural norms of a population increased comfort in dealing with diversity and the use of more effective treatment plans. Furthermore, capturing data about race and identity enabled programs to examine and address gaps in practice. They also noted many challenges and obstacles in implementing the changes identified in these key findings. Specifically, the cost associated with providing interpreter services is high, data collection related to race and ethnicity is often uncomfortable for staff, and the size of an organization can impede progress (private practices do not have the same regulations; there needs to be more control over smaller practices).

Lok Wong

The third presenter was Lok Wong from National Committee for Quality Assurance (NCQA). Wong began the presentation by sharing that for 10 years NCQA has united diverse groups around a common goal: improving health care quality. The mission of the organization is to improve quality of care, and the vision is to transform health care through measurement, transparency and accountability by providing information on quality of care in the U.S. They ask the following question: do our current quality of care methods measure safe, effective, patient-centered, timely, efficient and equitable health care?

NCQA has three projects related to cultural competency and health disparities: Health Disparities in Medicare, Feasibility of Evaluating CLAS in Health Plans, and Disparities in Cardiovascular Care. Data related to these projects has shown that while the quality of care is improving for everyone, there is still a persistent gap between racial and ethnic groups, for instance, blacks and whites. In addition, they have found that some plans are doing better than others. Obviously something is working and we really need to understand the characteristics of the organizations that are successful. However, not all of the plans can report on all of the measures, therefore the disparities within plans warrant further review. Regarding language needs, NCQA found that though it varies by plan type and region, there are large unmet language needs that are associated with more communication problems and lower ratings of doctor communication. Language services for patients with limited English can lead to better health outcomes and generic or targeted quality improvement interventions can improve quality and reduce disparities.

In addition to the above, NCQA developed a CLAS framework based on the Office of Minority Health National CLAS Standards. Their expert panel identified the following topics of importance: developing an infrastructure for data collection, tracking/reporting HEDIS by race and language data, implementing quality improvement activities/developing strategic plans, ensuring qualified interpretation, providing effective language access at the point of care, providing culturally competent care at the point of care, and engaging communities/developing partnerships.

Finally, Wong shared that both plans and purchasers have provided feedback about the CLAS framework. While most plans are interested in cultural competence and have addressed at least one component, few have capabilities in all three areas. Purchasers are not as aware of health disparities or may not have an interest in improving quality of care. Lastly, data collection is sometimes incomplete and variable.

Amy Wilson

Amy Wilson, from the Joint Commission on Accreditation of Healthcare Organizations, presented on what her organization is learning about healthcare, language and culture. The Joint Commission is a non-governmental, non-profit organization that has accredited 16,000 organizations and has influence and agreement with the Centers for Medicare & Medicaid Services (CMS). What they know:

- Healthcare disparities exist, we no longer need to prove this
- There are changing demographics across the nation
- The health care system is strained and overburdened, struggling to meet standards and goals with limited funds
- There have been various recommendations such as the need for interpreters, better data and better tools
- There is a desire for regulatory or accreditation push, and the Joint Commission standards may not be enough.

The Joint Commission wants to know the following: How can existing national recommendations be operationalized? How prepared are health care providers to meet the needs of diverse patients (language, culture, religion, gender, etc.)? Are health care

providers aware of the needs of diverse patients? Are existing accreditation standards enough? How can we provide the needed “push” without overburdening the system? To research the answers to these questions, the Joint Commission consulted with advisory groups, compared their standards to CLAS standards, reviewed accreditation recommendations, developed and disseminated a questionnaire and conducted a literature review. They found that there is not enough evidence, data, buy-in, or awareness of the issue.

They then developed a project called Hospitals, Language and Culture: A Snapshot of the Nation. This project is a two-and-a-half-year study, the largest qualitative study of its kind, that’s main goal is to gain greater understanding of the perspectives and experiences of hospitals across the nation. The research questions for the project are: What are the challenges that hospitals across the nation are facing as they provide health care to an increasingly diverse patient population? What are hospitals across the nation doing to address these challenges? Are there emerging practices that can be shared and replicated to help address issues related to CLAS?

The Joint Commission’s other project is: Understanding Adverse Medical Events for Minority Patients with Limited English Proficiency. The purpose of this project is to investigate the epidemiology of adverse events and near misses attributed to patient-provider communication problems related to language barriers and to identify potential quality improvement interventions for limited English proficient patients. They are working with six hospitals in six different states and hope to get information on the impact of LEP status on the occurrence of adverse events, identification of causative and contributing factors, and potential preventative strategies.

Finally, Wilson reported that the Joint Commission has a new standards requirement – IM.6.20: Language and communication needs documented in patient record. She added that the field is not yet ready to identify race and ethnicity.

In response to an audience question, Wilson stated that there is a Joint Commission standard related to cultural competency: Orientation on cultural competency and diversity. However, this does not speak to ongoing training and the training does need to be specific to the community.

Panel Wrap-up

When the panelists concluded their presentations, the facilitator asked the following question: What is it that you want the audience to do with this information and what can they do to inform your work?

- Wilson asked the audience to provide suggestions for hospitals for their study. In addition, stories from frontline staff provide helpful information.
- Reavis is interested in feedback about what is not feasible. Also, since they normally hear from providers, they are interested in different perspective that other stakeholders can provide.
- Wong added that it is helpful to share failures as well as successes.

Closing

James Allen Crouch, President, CPEHN Board of Directors

Jim Crouch reflected on the events of the day. He discussed the various panels and that he noticed people networking and sharing throughout the day's events. Crouch seemed especially impressed with the small group breakout sessions because of the engagement of the participants and the sharing of ideas. He also enjoyed the opportunity to hear the ideas offered and the validation of the existence of a cultural divide.

Moreover, Crouch explained that the presentations on data and the work that folks are doing to implement measurable standards are keys to accountability for this work. He suggested that this was a great way to end the gathering.

All participants recognized the importance of the intersection of race, ability, age, spirituality, ethnicity, etc., the multiplicity of these factors as we think about cultural competence and how our system needs to respond to these needs.