

Improving Cultural Competency in Children's Health Care

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Project Overview

- Funded by The California Endowment (Thank You !)
- Focus to integrate Quality Improvement and Cultural Competency
- Primary focus in California for expertise, dissemination and pilot testing
- Project Chairperson – Sunita Mutha, MD
- May 2004 – August 2005



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Objectives

- Create a strategy for improving cultural competency in children's healthcare within a specific framework used in most of our Quality Improvement projects
- Develop practical strategies that healthcare organizations – primary care 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

“Change Package”



Methods: Existing Resources

- Setting the Agenda for Research on Cultural Competence in Health Care: Final Report
- National Standards for Cultural and Linguistically Appropriate Services (CLAS)
- The Organizational Cultural Competence Assessment Profile by the Lewin Group
- Research of many others in the field



Methods: Advisory Panel

- Representatives from organizations that have major impact on the delivery of health care for children and that have undertaken activities in this field
- Helped identify the members of the Expert Panel
- Kept us informed of major initiatives in the field
- Provided input on our materials
- Shared information about this initiative with their organizations



Methods: Expert Panel

- Individuals with academic or practical expertise in the area of cultural competency
- Participated in a two day meeting in November, 2004
- Reviewed a draft copy of the strategies, changes and measures
- Helped integrate these with the Care Model for Child Health
- Revised and condensed the Change Package several times
 - ◆ Focused on the 'first layer'



Methods: Pilot Testing

- Purpose was to gain understanding of the feasibility and usefulness of the proposed strategies, changes and measures
- Qualitative data
- Used two types of piloting
 - ◆ Providers incorporated one or more of the strategies into their clinic practices or tested measures and reported on their feasibility
 - ◆ Providers evaluated the entire list of strategies and measures and assessed their own site



Change Package

- Three key elements
 - ◆ A conceptual framework that describes the features of the ideal system (Care Model for Child Health)
 - ◆ A set of changes and strategies that have proven to be or promise to be effective in achieving improvements
 - ☐ Change concepts
 - ◆ A set of measures that enable tracking of progress towards improvement goals
 - ☐ Outcome Measures
 - ☐ Process Measures
 - ☐ Structural Measures
 - ☐ Balancing Measures



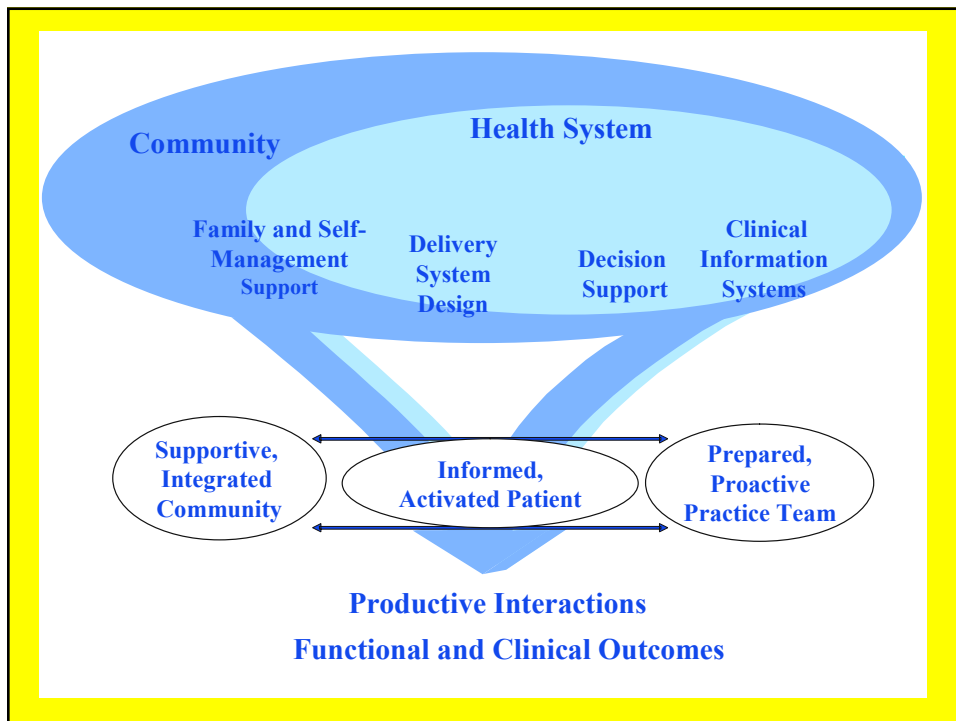
Framework

■ Care Model for Child Health

- ◆ A modification of the Chronic Care Model created by Ed Wagner, MD, MPH and his colleagues at Improving Chronic Illness Care (ICIC) at Group Health Cooperative in Seattle
- ◆ Used in all NICHQ Collaboratives (Quality Improvement projects) that focus on chronic illness care and preventive services:

Asthma	Obesity/Overweight
ADHD	Perinatal Care
Immunization	Epilepsy
Oral Health	Developmental Screening
Cystic Fibrosis	Medical Home

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Change Concepts

- Within each of the six components of the Care Model for Child Health
 - ◆ Community Resources (2)
 - ◆ Health System and Organization (3)
 - ◆ Family and Self-Management Support (2)
 - ◆ Decision Support (2)
 - ◆ Delivery System Design (2)
 - ◆ Clinical Information System (2)

Where to begin...

- Assess organizational and individual understanding of culturally and linguistically effective care and implement appropriate strategies for making and sustaining improvements. (HS)
- Provide linguistically effective care at all points of contact. (HS)
- Prepare families to be engaged, empowered and educated so they are active partners in their child's care. (F/SMS)

Measures

- Core Measures
 - ◆ Essential to meeting the goals of cultural competency
 - ◆ Outcome, process, and structural
- Additional Measures
 - ◆ Important but somewhat less significant
 - ◆ Includes balancing measures

Where to begin...

Outcome Measure

- *Disparities*: Magnitude of difference among racial/ethnic groups in key clinical outcomes.

Process Measures

- *Language*: Percent of patients receiving care in their preferred language.
- *Identification of race, ethnicity, and language preference*: Percent of children/families with R/E, language preference, and desire for an interpreter identified in data system or in the medical record.

Key Findings

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



Key Findings (con't)

- There are many challenges and obstacles when trying to implement the recommended changes.
 - ◆ Cost of providing interpreter services
 - ◆ Data collection around race and ethnicity is often uncomfortable for front line staff
 - ◆ Size of organization can impede progress



Next Steps

- Disseminate this information
 - ◆ Hard copies of the findings document
 - ◆ Electronically in PDF format
 - 📄 www.nichq.org
 - 📄 Links on other websites - CPEHN
- Include the initial changes and measures in all future NICHQ Collaborative projects
- Future cultural competency project?