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Creating a Culturally Competent Health Care System

For more than a decade, cultural competency has been an emerging issue in health care delivery. California, as it often does in health care trends, has been leading the way.

An Agency for Healthcare Research and Quality report, "**Cultural Competence California Style**," outlined efforts that helped set the national stage for innovative practices to improve health care for diverse populations in 2006.

Now the stage is changing.

The U.S. Census Bureau announced last month that for the first time, white infants no longer comprised a majority of births. Hispanic, black, Asian and other non-white infants accounted for 50.4% of U.S. births in the 12-month period that ended last July.

In California, which has been a "majority minority" state since the late 1990s, communities of color account for about 60% of the population.

With the Affordable Care Act adding as many as 30 million newly insured Americans to the system -- up to three million in California -- the need for health care providers who understand language and cultural differences will be greater than ever.

The number of people in the U.S. who don't speak English as their native language has grown 140% over the past three decades, according to the Census Bureau. While it may not continue at that pace, the number of Americans for whom English is a second language is expected to continue growing.

California, with one of the most diverse populations in the country, has large -- and growing -- populations whose first language is Spanish, Chinese, Tagalog, Korean, Vietnamese or another of the 100 languages spoken in the state. Officials estimate about 40% of Californians speak a language other than English at home.

We asked stakeholders how legislators, policymakers, educators and business leaders can best prepare California's health care system for an increasingly diverse population.

We got responses from:

- Steven Green, President, California Academy of Family Physicians
- Ellen Wu, Executive director, California Pan-Ethnic Health Network
- Ignatius Bau, Health policy consultant, former Director of Culturally Competent Health Systems for The California Endowment
- Kimberly Chang, Clinic director, Frank Kiang Medical Center, at Asian Health Services in Oakland
- Carmella Gutierrez, President, Californians for Patient Care
- Boris Kalanj, Senior Program Associate, California Health Care Safety Net Institute

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Specific Steps Toward Improvement Identified

Steven Green
President, California Academy of Family Physicians

Race, ethnicity and spoken language should not be risk factors for one's health status or for receiving inferior care. Yet in California, a **2010 Office of Statewide Health Planning and Development report** identified a wide range of health disparities by race.

To address such disparities, the California Academy of Family Physicians co-convened the **Medical Leadership Council** on Cultural Proficiency from 2004 to 2011, supported by The California Endowment. This group of physician and staff leaders of medical specialty societies, county medical societies, ethnic medical associations and health systems learned that the following steps are critical to address health inequities:

- Providing language access to patients;
- Improving cultural proficiency among physicians and others providing care; and
- Increasing workforce diversity among physicians and others.

In addition to working within the mix of state and federal laws and standards set by accrediting bodies to support improvements, we can take additional steps in each of those areas.

Providing Language Access: Since 2009, California law has required health plans and insurers to provide language services to their enrollees and collect data on race, ethnicity and language to assist efforts to end health disparities. Physicians and other health care professionals must learn to care effectively for patients whose primary language is not English.

Covering the cost of interpreters and other language access services remains an issue for solo and small physician practices outside these networks. By remedying this problem, state, federal and private payers can help ensure better access for patients.

Improving Cultural Proficiency: Understanding patients' cultural context is also key. Since 2006, California law has required physician CME courses to include curriculum in cultural and linguistic competence in all courses that address direct patient care. Medical schools and residency programs can also play a major role by providing training. The White Memorial Family Medicine Residency Program in East Los Angeles, for example, follows the **Curriculum for Culturally Responsive Health Care**.

Increasing Workforce Diversity: A **report on diversity** among California physicians found that some races and ethnicities, including Native American, African American, Latino and some Asian and Pacific Islanders, are particularly underrepresented in medicine. Recruiting health care professionals from these communities will help improve language access and cultural proficiency. To this end, "pipeline" projects are essential, as are increased scholarship and loan-repayment programs.

The **Future Faces of Family Medicine** program, for example, supported by the California Academy of Family Physicians and designed by family medicine residents, encourages high school students to consider careers as primary care physicians. The eight-week-long program exposes students to medical topics and ongoing mentoring.

So-called "minorities" are already the majority in our state. The health care system must take the necessary steps to deliver the care all Californians deserve.

We Must Go Broader, Think Bigger, Be More Inclusive

Ellen Wu
Executive director, California Pan-Ethnic Health Network

Creating a culturally competent health care system is now an imperative for California. With the expanded coverage options through the Affordable Care Act, more than 4.5 million people of color will be newly eligible for health insurance in 2014. We must ensure that our health care system can meet the needs of diverse patients.

We already know from our study, "**Achieving Equity by Building a Bridge From Eligible to Enrolled**," that about 110,000 patients could potentially miss the opportunity to enroll in California's Health Benefit Exchange if outreach and enrollment efforts do not address language barriers experienced by our communities.

While California is still leading the country with our **language access laws** -- requiring all health plans and insurers to provide interpreters and translated documents -- we must go broader, think bigger and be more inclusive to advance the larger issue of cultural competency.

CPEHN's report, "**Taking Cultural Competency From Theory to Action**," provides principles for implementing cultural competency based on interviews with national leaders. Our work since its release has built upon our findings to identify key elements of a culturally competent health care system:

- **Involve communities of color in decision-making and all stages of implementation.** Community participation is the most essential component of cultural competency, and communities of color must be an integral partner in the development and implementation of policies and programs. Meaningful community participation helps to allocate resources effectively and establishes an accountability system to ensure quality services.
- **Strengthen data collection efforts.** We must institute standardized systems to collect demographic data to identify differences in coverage, utilization and care, as well as develop policies that promote equal access and treatment. California must collect granular data on subpopulations to truly understand the needs of our diverse communities.
- **Invest in culturally and linguistically appropriate outreach, with particular focus on those with the highest need.** Resources must be designated for in-person and telephone assistance to communities with the highest needs including low-income populations, immigrants, people who do not speak English well and persons with disabilities.
- **Integrate cultural competency efforts into all systems of the organization.** Cultural competency must be viewed as integral to the organization and incorporated into all aspects of its operations, including disease management, quality improvement and patient safety initiatives.
- **Provide ongoing staff training.** Staff training ensures buy-in based on an understanding of why changes are necessary and builds staff capacity to successfully implement the project. Furthermore, familiarity with patients' cultures helps promote an environment of understanding and appreciation for diversity.
- **Invest in primary care and workforce diversity in underserved areas.** California must to be ready to meet the needs of the newly insured by increasing and diversifying our workforce and strengthening the capacity of our safety-net providers. We need to establish programs to recruit, train and retain people of color in the health professions.

We look forward to working with policymakers, advocates and community leaders to implement these recommendations and help California lead the way toward a more culturally competent health care system.

Cultural Competency Essential to Reform

Ignatius Bau
Health policy consultant, former Director of Culturally Competent Health Systems for The California Endowment

The California Endowment has invested in improving the cultural competency of health care providers as part of its mission to improve the health of California's underserved communities. Cultural competency will become even more essential as health care reform is implemented and the California Health Benefit Exchange provides expanded health insurance coverage to 2.6 million Californians -- 67% of whom will be persons of color and 40% of whom will need health care interpretation services.

The Endowment has used multiple strategies to advance cultural competency. At the system-change level,

we have supported policy changes that ensure cultural competency as part of health care quality. Advocacy organizations have secured milestone California legislation such as SB 853 requiring all health plans to provide language access and AB 1195 requiring cultural competency in continuing medical education. At the national level, we have supported the Joint Commission, National Committee for Quality Assurance (NCQA), and National Quality Forum as they incorporate cultural competency, language access and health care disparities reduction into their standards for hospitals, health plans and other health care providers. The Joint Commission and NCQA have continued to incorporate cultural competency in their standards for medical homes and accountable care organizations. As a result of these policy changes, every health care system will be increasingly accountable for its cultural competency and its effectiveness in providing equitable health care to diverse populations.

At a practice level, The Endowment supported California's public hospitals and private hospital systems -- Kaiser, Catholic Healthcare West, Sutter Health, and St. Joseph's Health System -- in implementing language access and cultural competency programs. We supported a statewide Medical Leadership Council on Cultural Proficiency, led by the California Academy of Family Physicians, to educate and engage physicians. And we partnered with the Association of American Medical Colleges, American Association of Colleges of Nursing and the American Dental Education Association to support the inclusion of cultural competency curricula in California's medical, nursing and dental schools.

Looking ahead, health care providers must continue to collect and use demographic data to effectively respond to the needs of their diverse patients. Quality measures must be stratified by race, ethnicity and language to continuously identify and reduce health care disparities. Health care systems also must be more responsive to other underserved populations that experience disparities: boys and men of color; the disabled; and gay, lesbian, bisexual and transgender individuals. Cultural competency will continue to be a key to quality for California's health systems and providers.

Setting Priorities for 'Perfect Storm'

Kimberly Chang
Clinic director, Frank Kiang Medical Center, at Asian Health Services in Oakland

If you think cultural competency is automatically achieved at our clinic, which serves primarily Asian patients, think again. But our ongoing work to provide culturally sensitive care can be a model for how other providers can improve their services in our increasingly diverse state.

While the "Asian" in our name does reflect specialization, our patients may be Chinese, Vietnamese, Korean, Filipino or from other Asian or Pacific Island nations -- all of which have very different languages and cultural needs. They may be immigrants or refugees who don't speak English or understand American culture yet. They may be Latinos or they might be African-American or second- or third-generation families who have lived in our neighborhood for decades.

Regardless of where they're from, we can only provide effective care if they feel comfortable coming in to see us and can understand our diagnoses and treatment instructions. If they don't, they'll delay necessary care and ultimately end up requiring more extensive, expensive treatments down the road. Often that leads to visits to hospital emergency departments, which can increase wait times -- and ultimately the cost of care -- for the rest of us.

Regardless of how the Supreme Court rules on health care reform, two facts are reality checks for health providers (according to 2011 research by the UC-San Francisco Center for the Health Professions): Patients will increasingly be more diverse (representing different cultures and levels of English proficiency) and health workers don't adequately reflect the diversity of their patients.

To prepare for this perfect storm, providers, educators and policymakers should prioritize the following:

- Insurers should reimburse for "enabling services," which can include vital positions like Patient/Health

Navigators, who interpret for patients and guide them through a confusing process of insurance eligibility, diagnoses, treatment protocols, etc.;
- Build career ladders that help to promote allied health workers, who are typically more diverse;
- Make sure that college training programs are located in regions facing the biggest shortages of diverse workers (e.g., the Central Valley and Inland Empire) -- and ensure that community colleges have *affordable* trade schools or certificate programs for these fields; and
- Train existing workers on specific needs of particular patients. "Looking like" patients or speaking the same language does not equal cultural competency.

The need for cultural competency is not a matter of "if" but rather "when" -- and "how." Some providers are paving the way, but others must follow -- with support from policymakers and educators.

Making the Most of Those 15 Critical Minutes

Carmella Gutierrez
President, Californians for Patient Care

Fifteen minutes. That's the average amount of time a physician spends with a patient. But when communication skills are limited due to language and cultural barriers, 15 minutes is not enough. Misunderstandings of diagnosis and miscommunication about treatment plans can affect the quality and cost of care. Patients may not comply with their doctor's instructions and suffer negative outcomes. More and more providers will tell you: culturally competent care isn't just desirable -- it can literally be a question of life and death.

At Californians for Patient Care, we talk to patients every day about the challenges of accessing health care. The system is difficult enough for individuals whose language and customs are already familiar to physicians; it is that much harder for those whose culture is not understood by their caregivers. Patients tell us they don't want to be difficult, but neither do they want to be ignored. Many are from cultures where asking questions of an authority figure is not acceptable, so they respectfully nod in agreement without understanding what their doctor said or what they should do once they leave. Subsequently, they return with worsened conditions.

Several well-known studies, including one by the Institute of Medicine, acknowledge that culturally competent care can improve outcomes, reduce medication errors, improve patient safety and result in health care cost savings.

Californians should feel confident that future generations of providers will be culturally competent caregivers. Public and private medical schools across the state have developed and implemented curricula and specialized education programs to encourage practice with underserved populations. California is also working to increase the makeup of its health care workforce to better reflect its racially and ethnically diverse demographics.

But we're not there yet. Policymakers need to implement incentives to create an environment in which both providers and patients are empowered to reclaim the personal nature of the caregiver-patient exchange. Cultural competency isn't just a question of literally speaking the same language. It means greater understanding of cultural differences that can affect communication and trust during examination, diagnosis and treatment.

The limited time a patient spends with a caregiver can mean the difference between life and death. Those precious minutes should not be wasted because of cultural barriers.

Start With Meaningful Data on Race, Ethnicity, Language

Boris Kalanj

Senior Program Associate, California Health Care Safety Net Institute

Persistent disparities in health care have been linked to the often substandard cultural competence of our health care systems. I will argue that our abilities to both eliminate disparities and build cultural competence begin with collecting meaningful data on patients' race, ethnicity and language (REaL) and continue with actively using these data variables to stratify the key measures of health care quality and safety. The ultimate goal is to identify gaps in care that may exist for certain demographic groups, and then do something to alleviate these gaps. If we could achieve widespread and reliable application of these steps throughout our health care systems, the cultural competence would likely increase while disparities decrease.

The California Health Care Safety Net Institute (SNI) has worked to spread the accurate collection and effective use of REaL data since 2009, most recently partnering with California Health Information Partnership and Services Organization (CalHIPSO) to integrate modules on REaL data into an online health IT training for primary care providers throughout the state.

Our REaL data journey started in 2009 with support from The California Endowment to conduct an assessment of real-life barriers and facilitators of REaL data collection and use among the 19 members of the California Association of Public Hospitals and Health Systems (CAPH). We found many leading strategies among these safety-net systems, from staff training to infrastructure changes and data integration. For example, UC-Davis Medical Center developed electronic health record pathways for staff to better capture their patients' REaL data, thereby significantly reducing the proportion of the missing data. Contra Costa Regional Medical Center and Contra Costa Health Services created fully interconnected patient demographic data collection systems spanning their hospital, clinics and health plan. SNI also identified several barriers, most notable of which is the lack of consensus on the optimal REaL data categories that fit payer and regulatory requirements, but meet the local community demographic profiles.

The latter problem is not endemic to public hospitals, but reflects a larger confusion among the local and national advisory and decision-making bodies. For example, the recent REaL data categories promulgated by the Institute of Medicine, the U.S. Department of Health and Human Services and California's Office of Statewide Health Planning and Development all differ from each other in significant ways. This absence of compatible categories is one of the main factors hindering the progress of health care systems to collect quality REaL data, in turn affecting their ability to uncover and understand disparities in care, and ultimately design effective interventions to eliminate them.

Therefore, if I had to prioritize one building block of cultural competence as the first order of business for our governmental, health care and community leaders, it would have to be a new concerted effort to agree upon a unifying set of categories for patient race, ethnicity and language that works at various levels, from local to national. This must be followed by the creation of powerful incentives for health care systems to reliably collect these data and use them to examine and ensure equitable care for their patients.