Cultural Competency

Purpose

The purpose of the *Cultural Competency* program is to ensure that the Plan meets the unique, diverse needs of all members; to provide that the associates of the Plan value diversity within the organization and to make certain members in need of linguistic services have adequate communication support. In addition, the Plan is committed to ensuring our providers fully recognize and care for the culturally diverse needs of the members they serve.

At the national level, the Plan is a member of the National Alliance for Hispanic Health, an organization with ties to the federal government that fosters the development of resources to improve Hispanics' access to and quality of health care. One of the Alliance's projects is the National Hispanic Family Health Helpline, (866) 783-2645. The Alliance also sponsored the report, "Genes, Culture and Medicines: Bridging Gaps in Treatment for Hispanic Americans," which the Plan started using in 2005 in educating providers about ways to reduce health disparities.

Objectives

The objectives of the Cultural Competency program are to:

- Identify members that have potential cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken;
- Ensure resources are available to meet the unique language barriers and communication barriers that exist in the population;
- Ensure providers care for and recognize the culturally diverse needs of the population; and

- Ensure associates are educated and value the diverse cultural and linguistic differences in the organization and the populations served.

Goals

The goals of the Cultural Competency Program are to:

- Improve communication to members for whom cultural and/or linguistic barriers exist;
- Decrease health care disparities in the minority populations we serve; and
- Improve associates' understanding and sensitivity to cultural diversity within the organization and the members served.

The delivery of culturally competent health care and services requires health care providers and/or employees to possess a set of attitudes, skills, behaviors and policies which enable the organization and staff to work effectively in cross-cultural situations.

Culturally and linguistically appropriate services (CLAS): Health care services that are respectful of, and responsive to, cultural and linguistic needs.[1]

The Plan endorses the view, promulgated by the federal government,[2] that achieving cultural competence will help the health Plan to:

- Improve services, care and health outcomes for current members (improved understanding leads to better adherence and satisfaction);
- Increase market penetration by appealing to potential culturally and linguistically diverse members;

[1] *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, U.S. Department of Health and Human Services, Office of Minority Health, December 2000.
[2] *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans*, Centers for Medicare and Medicaid Services and Agency for Healthcare Research and Quality, 2003

- Enhance the cost-effectiveness of service provision; and
- Reduce potential liability from medical errors and Title VI (Civil Rights Act) violations.[3]

The components of the Plan's Cultural Competency program include:

Data Analysis

- Analysis of claims and encounter data to identify the health care needs of the population
- Collection of data on race, ethnicity and language spoken for members

Community-based Support

Outreaches to community-based organizations which support minorities and the disabled to be sure that the existing resources for members are being utilized to their full potential.

Diversity of Health Plan Associates

- The Plan does not discriminate with regards to race, religion or ethnic background when hiring associates.
- The Plan recruits diverse talented associates in all levels of management.
- The Plan ensures that bilingual associates are hired for areas that have direct contact with members to meet the needs identified.

[3] Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected. Department of Justice regulations (28 CFR Section 42.405(d)(1)) state: "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."

Diversity of Provider Network

- Providers are inventoried for their language abilities and this information is housed in the Diamond system and printed in the Provider Directory, so that members can choose a provider that speaks their primary language.
- Providers are recruited to ensure a diverse selection of providers to care for the population served.

Linguistic Services

- Providers will identify members that have potential linguistic barriers for which alternative communication methods are needed and contact the Plan to arrange appropriate assistance.
- Members may receive interpreter services at no cost when necessary to access covered services through a vendor, as arranged by the Customer Service department.
- Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by the Plan's Customer Service department.
- Written materials are available for members in large print format, and certain non-English languages, prevalent in the Plan's service area.

Electronic Media

- Telephone system adaptations – members have access to the TTY/TDD line for hearing impaired services. The Customer Service representatives have responsibility for any necessary follow-up phone calls to the member.

Provider Education

- Educated regarding the Cultural Competency Program through the Provider Manual
- Receive a Cultural Competency Checklist to assess their office's Cultural Competency

Determination of Performance Improvement Projects

- Focused assessments to identify opportunities for improvement
- Setting priorities and assignments

Cultural Competency Survey

Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health Care Services.

Developed by **Tawara D. Goode, National Center for Cultural Competence, Georgetown University**

Target Group: **Health Care Workers**

Purpose

1. To increase individual awareness of practices, beliefs, attitudes and values that promote and hinder cultural and linguistic competence in the delivery of health care.
2. To identify training needs.

Length of Survey

30-item list

Distinguishing Characteristics

Divided into three categories:

1. Physical Environment, Materials and Resources
2. Communication Styles
3. Values and Attitudes

Each item is rated on a three-point scale.

Self-Assessment Checklist for Personnel Providing Primary Health Care Services

Georgetown University Center for Child and Human Development - National Center for Cultural Competence

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices, which foster cultural and linguistic competence at the individual or practitioner level.

DIRECTIONS: Select A, B or C for each item listed below.

A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials and Resources

____ 1. I display pictures, posters, artwork and other décor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

____ 2. I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I

insure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

____ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

Communication Styles

____ 5. When interacting with individuals and families who have limited English proficiency, I always keep in mind that:

- Limitation in English proficiency is in no way a reflection of their level of intellectual functioning.
- Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
- They may or may not be literate in their language of origin or English.

____ 6. I use bilingual/bi-cultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

____ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

____ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

____ 9. When possible, I insure that all notices and communiqués to individuals and families are written in their language of origin.

____ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method.

Values and Attitudes

____ 11. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

____ 12. I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my program or agency.

____ 13. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors which show cultural insensitivity, racial biases and prejudice.

____ 14. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

____ 15. I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

____ 16. I accept and respect that male-female roles may vary significantly among different cultures and ethic groups (e.g., who makes major decisions for the family).

____ 17. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families or roles and expectation of children within the family).

____ 18. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

____ 19. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

____ 20. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.

____ 21. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

____ 22. I recognize and accept that folk and religious beliefs may influence an individual’s or family’s reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder or special health care needs.

____ 23. I understand that grief and bereavement are influenced by culture.

____ 24. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

____ 25. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

____ 26. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

____ 27. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.

____ 28. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

____ 29. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

____ 30. I advocate for the review of my program or agency mission statement, goals, policies and procedures to insure that they incorporate principles
and practices that promote cultural and linguistic competence.

There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.

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