

THE NATIONAL QUALITY FORUM

TO: NQF Members

FR: NQF Staff

RE: Pre-voting review for *National Voluntary Consensus Standards for a Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency*

DA: October 13, 2008

In October 2007, NQF was tasked by The California Endowment and The Commonwealth Fund to identify and endorse a comprehensive national framework for evaluating cultural competency across all healthcare settings, as well as a minimum set of preferred practices based on the framework. A Steering Committee of 19 individuals representing the range of stakeholder perspectives was convened and reviewed a proposed framework and considered for endorsement a total of 62 preferred practices; it recommends 44 practices for endorsement (one practice was previously endorsed by NQF) along with a framework for measuring and reporting cultural competency. This draft report recommends that these 44 practices and the framework be endorsed as voluntary consensus standards.

NQF acknowledges that many organizations are currently conducting important work in the field of cultural competency. NQF views this work as complementary. Recently, for example, The Joint Commission launched a project to develop accreditation standards for hospitals that will promote, facilitate, and advance the provision of culturally competent patient-centered care. The project will build upon The Joint Commission's *Hospitals, Language, and Culture: A Snapshot of the Nation* study, which identified how the challenges associated with culture and language are being addressed at 60 hospitals across the country. The Joint Commission, in collaboration with the National Health Law Program, will also develop an implementation guide to prepare Joint Commission surveyors and accredited hospitals for the release of the new standards addressing culturally competent patient-centered care. Additionally, the National Committee for Quality Assurance (NCQA) has been working to develop a cohesive module of standards suitable for evaluating efforts to improve the provision of culturally and linguistically appropriate services and to identify and reduce care deficiencies related to National Standards on Culturally and Linguistically Appropriate Services (CLAS)/Disparities. These standards are intended to offer health plans and other organizations a guide for internal assessment and improvement. NCQA intends to release the standards in 2009 and hopes to incorporate elements of the standards into existing accreditation programs over time. The above activities, build on the foundation provided by the release of CLAS by the U.S. Department of Health and Human Services, The Office of Minority Health in 2001. NQF believes the practices endorsed through this will project help inform the effector arms of organizations like The Joint Commission and NCQA through accreditation and measure development.

The draft document, *National Voluntary Consensus Standards for a Framework and Preferred Practices for Measuring and Reporting Cultural Competency*, is also posted on the NQF web site, www.qualityforum.org, along with the following additional information:

- practice evaluations; and

- summaries of the Steering Committee deliberations and recommendations.

Pursuant to section II.A of the Consensus Development Process v. 1.8, this draft document, along with the accompanying material, is being provided to you at this time for purposes of review and comment only – not voting. You may post your comments and view the comments of others on the NQF website. **NQF Member comments must be submitted no later than 6:00 pm EST, November 12, 2008.**

NQF is now using a program that facilitates electronic submission of comments on this draft report. **All comments must be submitted using the online submission process.**

Supporting documents related to your comments may be submitted by **email** to culturalcompetency@qualityforum.org with “*Comment - Cultural Competency*” in the subject line and your contact information in the body of the email.

Thank you for your interest in the NQF’s work. We look forward to your review and comments.

Endorsing a Comprehensive Framework and Preferred Practices for
Measuring and Reporting Cultural Competency

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Practices for Quality Measurement and Reporting” A-1

1 ENDORSING A COMPREHENSIVE FRAMEWORK AND PREFERRED PRACTICES FOR
2 MEASURING AND REPORTING CULTURAL COMPETENCY
3

4
5 INTRODUCTION
6

7 Racial and ethnic disparities in healthcare are well documented and indicate that minorities
8 disproportionately suffer from higher rates of disease and death and tend to receive a lower
9 quality of care even when factors such as access, health insurance, and income are taken into
10 account.¹ The Institute of Medicine (IOM) addressed this issue in a report, *Unequal Treatment:
11 Confronting Racial and Ethnic Disparities in Health Care*, and noted that one major contributor to
12 health disparities is a lack of culturally competent care.² Providing culturally appropriate
13 services not only has the potential to reduce disparities and improve outcomes, but also
14 increase the efficiency of clinical and support staff as well as create greater satisfaction among
15 the patient.¹
16

17 Efforts to define and classify cultural competency are ongoing. In 2001, the Department of
18 Health and Human Services' Office of Minority Health published standards for culturally and
19 linguistically appropriate services (CLAS) for healthcare organizations.³ These standards were
20 an initial move to provide structure to what constitutes culturally appropriate healthcare
21 services; the National Committee for Quality Assurance (NCQA) now has an awards program
22 for health plans that demonstrate innovative approaches in meeting CLAS standards. In
23 addition, policy-level approaches for cultural competency have been introduced by The Joint
24 Commission and the Centers for Medicare and Medicaid Services. The Joint Commission
25 recently launched a project to develop hospital accreditation standards to promote, facilitate,
26 and incentivize the provision of culturally competent, patient-centered care and tNCQA has
27 been working to develop a cohesive module of standards suitable for evaluating efforts to
28 improve the provision of culturally and linguistically appropriate services and to identify and
29 reduce care deficiencies related to CLAS/Disparities.
30

31 Developing culturally competent healthcare systems is an integral and vital component in
32 reducing disparities and delivering patient-centered care. Moreover, even as healthcare
33 systems improve, without the provision of culturally accurate and appropriate services, medical
34 errors, misunderstandings, and a lack patient compliance may still increase due to differences in
35 language or culture. This project aims to promote culturally competent care and to reduce
36 disparities by endorsing a comprehensive framework for measuring and reporting cultural
37 competency and by endorsing preferred practices to provide culturally competent care.

38

39 Purpose

40 The purpose of this project was to:

- 41 • Endorse a *comprehensive* national framework for evaluating cultural competency across
42 all healthcare settings;
- 43 • Endorse a minimum set of preferred practices for cultural competency based on
44 the framework. These practices are both specific and overarching – i.e., covering
45 all settings and providers; and
- 46 • Identify high-priority research areas to advance the evaluation of cultural
47 competency and its impact on care.

48

49 Defining Cultural Competency

50 Over the past decade, cultural competency has had a range of meanings⁴. For purposes of this
51 project, the NQF's definition attempts to address both the individual and organizational aspects
52 of cultural competency, as well as the structural and process elements:

53 *Cultural competency is the ongoing capacity of healthcare systems, organizations and*
54 *professionals to provide for diverse patient* populations high quality care that is safe, family- and*
55 *patient- centered, evidence-based, and equitable.*

56

57 Healthcare cannot be of high quality without being delivered in a culturally competent
58 manner.[†] In 2001, *Crossing the Quality Chasm* outlined six aims for the quality of healthcare:

* The term “patient” refers to the individual recipient of care – i.e. patient, client, legal surrogate or person.

59 safe, effective, patient-centered, timely, efficient, and equitable.⁵ High quality care implies
60 state-of-the-art care grounded in evidence-based clinical practices. According to the IOM's¹⁹
61 "equity aim" for health system improvement, quality of care a patient receives should not differ
62 because of such characteristics as gender, race, age, ethnicity, income, education, disability,
63 sexual orientation, or location of residence. However, while the quality should not differ, the
64 care is patient-centered only when clinicians treat each patient as an individual, within the
65 context of his or her care.²⁰⁻²¹ This requires a partnership among clinicians, patients, and
66 families to ensure that healthcare decisions take into account patient preferences. In order to be
67 patient-centered, evidence-based, and equitable, culturally competent healthcare requires oral
68 and written language access, cultural differences and attention to the patients' health literacy
69 needs.

70
71 Cultural competency is achieved through policies, learning processes, and structures by which
72 organizations and individuals develop and support the attitudes, behaviors, practices and
73 systems that are needed for effective cross-cultural interactions. Factors that can effect cross-
74 cultural interactions, include but are not limited: to socio-cultural factors such as race/ethnicity,
75 nationality, language, health literacy, gender, socioeconomic status (SES), immigrant status (age
76 at immigration and length of time in the United States), physical and mental ability, mental
77 health, sexual orientation and gender identity, religion, health literacy, age, and occupation.⁸
78 These factors can be conceptualized as cultural group identities. Individuals' affiliations to
79 cultural groups are complex, with individual differences based on the group identity profile
80 and strength of the group identities.¹⁸ For example, a second generation Hispanic patient of
81 higher SES may have a different cultural reference point than a recent Hispanic immigrant of
82 lower SES. That is, the group identity profile, as well as the strength of group identities, are
83 likely to differ and these differences may affect an individual's interactions with the healthcare
84 system.

85
86 It is important to note that children's cultural experiences and identities can be and are
87 frequently different from their parents. For the most part, in the standards recommended in

† High quality healthcare is delivered in a safe, effective, patient-centered, timely, efficient, and equitable manner that is state-of-the-art and evidence-based.

88 this document, there are not substantial differences between adults and children with respect to
89 culturally competent care, and thus the use of "patients" and "patients and families" is inclusive
90 of children. However, children do exist as a distinct population who may have divergent needs
91 from their parents. For example, a child raised in the United States may have a very different
92 cultural experience from his/her first generation immigrant family. In infancy and early
93 childhood the child's culture will be more reflective of the family, and the clinical encounter will
94 generally be addressed to the caregiver alone. However, as the child grows into middle and
95 late childhood, the child is exposed to beliefs, values, cultural practices, and language that are
96 different from their parents. The clinical encounter will gradually transition to include the child
97 and by late adolescence, will be focused on the adolescent alone. This is a complex transition
98 because of the autonomy issues of the increasingly independent adolescent, but also because the
99 child is likely to have different health beliefs from his/her family. In summary, in the pediatric
100 population, communication must be family centered *and* child centered in a developmentally
101 appropriate manner.

102
103 NQF recognizes that individuals with physical, cognitive, or emotional disabilities experience
104 many of the same barriers to high quality, safe care as do those who have limited English
105 proficiency or are from other cultural backgrounds. Groups who share a particular disability –
106 such as limitations in sight, hearing, speech, or mobility – often share a unique culture among
107 themselves, such that communication and cultural differences are also sources of barriers in
108 their healthcare. Identification of preferred practices to reduce or eliminate these barriers,
109 however, was beyond the scope of this project. The project's Steering Committee, however,
110 strongly recommends that an additional report to address these barriers should be developed
111 under the guidance of a new, appropriately constituted Steering Committee that represents the
112 knowledge and experience needed to address cultural barriers resulting from physical,
113 cognitive, or emotional disabilities.

114
115 **Identifying the Framework**

116 A Steering Committee guided the development of an evidence-based framework,[‡] relying on
117 the commissioned paper, “*A Cultural Competency Framework and Preferred Practices for Quality*
118 *Measurement and Reporting*” (appendix A).

119

120 Purpose of the Framework

121 Despite research efforts to build an evidence base to support that cultural competence would
122 result in improved health outcomes and decreased system costs, there is a noticeable absence of
123 a broadly defined framework, logic model, or definition that would move the field beyond race
124 or ethnic specific interventions.⁶ A Nationally endorsed framework around cultural competence
125 can serve as a road map for the identification of a set of preferred practices and performance
126 measures, as well as identify areas requiring additional research or development. The evidence-
127 based framework establishes a conceptual model to identify and organize NQF-endorsedTM
128 preferred practices and performance measures based on a set of cultural competency related
129 domains and subdomains that are applicable to multiple settings of care and providers of care.
130 The framework also serves as the basis to assess what is currently available and to identify areas
131 where gaps in practices exist. Guided by the framework, a set of preferred practices and
132 measures should provide comprehensive evaluation and reporting tools to ensure that care is
133 delivered in a culturally competent manner.

134

135 The framework is intended to be comprehensive and applicable to all healthcare settings and all
136 providers of healthcare. The forty-five preferred practices that comport to the framework are
137 also broadly applicable. While some of the specifications may be more easily implemented at
138 larger healthcare facilities or large physician group practices, they can be adapted to also work
139 in a single physician’s office or a small rural hospital.

140

141

[‡] This framework is intended for all healthcare organizations (health plans, hospitals, small and large physician group practices, community-based organizations, clinics, nursing homes, dialysis centers, ambulatory care centers) delivering care, including mental health services and oral health. Its audience is all employees of those organizations. For the purposes of this framework, healthcare professionals is defined as: physicians, administrators, nurses, physical and occupational therapists, linguistic services providers, psychologist social worker and any one who provides care to a patient.

142 **Guiding Principles**

143 Guiding principles for measuring and reporting cultural competence provide broad themes and
144 direction that, if uniformly adopted by all stakeholders, promote standardized measurement
145 and reporting, drive practice improvement and measure development, and support
146 implementation. The guiding principles are intended to be overarching and/or cross-cutting
147 across all (or multiple) domains of the framework presented in the next section.

148

149 Four guiding principles are recommended:

150

151 **Principle 1.**

152 Cultural competency in healthcare embraces the concept of equity with equal access to quality
153 care and non-discriminatory, patient-centered practices by healthcare providers.

154

155 **Principle 2.**

156 Cultural competency is necessary, but not sufficient, to achieving an equitable healthcare
157 system.

158

159 **Principle 3.**

160 Cultural competency should be viewed as an ongoing process and a multi-level approach with
161 assessments and interventions needed at the system, organizational, group, community, and
162 individual levels.^{7,8} Cultural competency should not be viewed as an endpoint, but rather
163 communities, organizations and individuals should strive for continuous improvement.⁹

164

165 **Principle 4.**

166 Successful implementation of cultural competency initiatives to achieve high-quality, culturally
167 competent, patient-centered care requires an organizational commitment with a systems
168 approach towards cultural competency.^{10,11,12} Addressing both organizational and clinical
169 aspects in managing diversity and the needs of a diverse workforce, the surrounding
170 community, and patient population are important factors in culturally competent care.¹³

171

172

173 **Framework Domains and Subdomains**

174 Standardized measurement and reporting of cultural competence requires identification of a
175 comprehensive framework that delineates the core competencies of high-quality, culturally
176 competent care. From this framework, preferred practices can be identified and/or mapped to,
177 and from those practices measures can be developed. Gaps in practices (or measures) should be
178 readily identifiable based on this approach.

179

180 The seven primary domains of measuring and reporting cultural competency are as follows:

- 181 1. Leadership
- 182 2. Integration into Management Systems and Operations
- 183 3. Patient-Provider Communication
- 184 4. Care Delivery and Supporting Mechanisms
- 185 5. Workforce Diversity and Training
- 186 6. Community Engagement
- 187 7. Data Collection, Public Accountability, and Quality Improvement (QI)

188

189 Each domain has sub domains that further delineate the components of each domain. While the
190 sub domains are parsed out in distinctive domains, many of them are cross-cutting and could
191 be applicable in other domains.

192

193 **DOMAIN ONE**

194 **Leadership**[§] recognizes that healthcare providers, clinical and organizational leaders, the Board
195 of Trustees and the community share responsibility for and play an essential role in the
196 development and implementation of cultural competency activities, in setting policy and
197 strategy, and in monitoring organizational performance.

198

199 **Domain 1.1**

[§] This domain refers to Leadership at the Board of Directors, Trustees, and C-Suite level.

200 **Organizational Culture.** A culture that is inclusive and values cultural differences; inclusive
201 signifies that the organization’s decisionmaking processes include diverse points of views from
202 within and outside the organization. When an organization values diversity it is demonstrated
203 in its practices, structure and policies. Organizational leaders are instrumental in setting
204 organizational culture.¹⁴

205
206 **Domain 1.2**

207 **Commitment to Diversity.** Cultural competency activities are most effective when the
208 organization’s top management, governing boards, executives, and policymakers, embrace
209 cultural competence and diversity and communicate this support throughout the organization
210 and community.^{15,16}

211
212 **Domain 1.3**

213 **Leadership Diversity.** Leadership at all levels of the organization, including the clinical and
214 administrative leaders, and Board of Trustees, reflects the community.¹⁷ Diversity is critical at
215 the levels of department chiefs and chairs as well. Leadership diversity increases the likelihood
216 that the needs of a diverse workforce and patient population are taken into account in
217 organizational decisionmaking processes.¹⁸ However, minorities have traditionally faced
218 barriers, or a “glass ceiling” effect, that have excluded them from upper management
219 positions.¹⁹ As such, healthcare organizations need proactive human resource strategies aimed
220 at diversifying the leadership ranks.

221
222 **Domain 1.4**

223 **Dedicated Staff and Resources.** An organization shows its commitment to cultural
224 competency by dedicating resources and designating staff for activities that promote cultural
225 competence. Dedicated resources can be shown by budgeting resources for cultural
226 competency activities.^{20,21,22} Dedicated staff can include an executive level staff member,
227 department or office that focuses on multicultural and/or linguistic issues. This can be
228 instrumental in coordinating organization-wide initiatives and monitoring progress towards
229 cultural competency goals.^{23,24}

230

231 **Domain 1.5**

232 **Policies.** Formal policies are in place that address cultural competency issues, such as
233 recruitment and retention of a diverse workforce, language services, and training and
234 development.^{25,26} Policies “express an organization’s intentions and provide a blueprint for
235 action”.²⁷ These internal policies should be in conformity with external regulatory and
236 statutory policies.²⁸

237

238 **Domain 1.6**

239 **Training and Development.** Training and development of leaders and staff at all levels of the
240 organization, including the Board of Trustees, on cultural competency issues.²⁹ Leadership
241 participation in training and development sends a signal to organizational members of its
242 commitment to cultural competency. (See also Domain Five Workforce Diversity and Training.)

243

244 **DOMAIN TWO**

245 **Integration into Management Systems and Operations** focuses on whether cultural
246 competency is integrated throughout all management and operations activities of the
247 organization, as this is an essential component to supporting the delivery of culturally
248 competent care.

249

250 **Domain 2.1**

251 **Strategic Planning.** The process includes environmental scanning, asset assessment, and needs
252 assessment of the communities served and formulation of goals related to cultural
253 competency.³⁰ Strategic goals reflect the organizational priorities for resource use and
254 deployment.

255

256 **Domain 2.2**

257 **Service Planning .** Organizations design services taking into account the needs of their patient
258 populations. This includes all elements of the healthcare encounter from admission to
259 discharge planning with the ultimate goal of improving access to care for all patients³¹ (e.g.,
260 expanding clinical hours to accommodate community work patterns, adapting to ethnic or

261 religious dietary preferences, and allowing for large families visiting or staying with
262 hospitalized patients.)^{32, 33}

263

264 **Domain 2.3**

265 **Performance Evaluation.** Job descriptions and performance evaluation systems include criteria
266 related to cultural competency.^{34,35} The performance evaluation process should include survey
267 of patient and family experience with care. This results in accountability for meeting cultural
268 competency goals. (See also Domain Seven Data Collection, Public Accountability, and Quality
269 Improvement.)

270

271 **Domain 2.4**

272 **Reward Systems.** Managers and staff are rewarded for meeting cultural competency goals.³⁶
273 Incentives help align the organizational members' goals with those of the organization:
274 behavior or performance that is reinforced tends to be repeated.³⁷

275

276 **Domain 2.5**

277 **Marketing and Public Relations .** Organizations promote and market their services through a
278 variety of media that reaches out to diverse populations, including ethnic newspapers,
279 television news programs, and radio stations.³⁸ Marketing and social marketing should also
280 emphasize the types of services offered such as interpretation and translation services, and
281 other cultural services. This should include the public reporting of performance and quality
282 information, including patient experience with care, in a format that can be easily understood
283 by the community. Raise public awareness of cultural competency activities and progress in
284 meeting goals.^{39,40} This can include a statistical annual report on patient demographics,
285 interpreter use and availability, translated materials, and staff training in cultural competency.
286 It also could include patient evaluation of services and providers. Such approaches can serve as
287 a marketing tool while enhancing the organization's image among diverse communities.

288

289

290 **Domain Three**

291 **Patient-Provider Communication** addresses all communication between the patients and
292 clinicians as well as support staff.

293

294 **Domain 3.1**

295 **Language Access.** Language access services are imperative to: increase access to care; improve
296 quality of care, patient satisfaction, health outcomes, and health status; and enhance or ensure
297 appropriate resource utilization.⁴¹ High quality language access services are needed at all points
298 of patient contact to improve provider and staff communication with patients with limited
299 English proficiency. Communication that is accurate and understandable increases the
300 likelihood of appropriate care and patient compliance. ^{42,43,44}

301

302 **Domain 3.2**

303 **Interpreter Services.** High quality interpreter services are imperative for patients to increase
304 the likelihood of receiving appropriate care. ^{45,46,47,48} An organization should first strive to
305 employ bilingual staff and providers. The bilingual proficiency of staff and providers needs to
306 be assessed, however, to ensure they speak the additional language(s) at a level such that high
307 quality services can be provided.⁴⁹ Having certified interpreters**⁵⁰ available for every point of
308 contact may not be an achievable goal but, at minimum, professionally trained and competent
309 interpreters should be employed “whose sole function in the healthcare setting is to interpret”⁵¹
310 since they have been clearly shown to be effective when compared to ad-hoc interpreters. ^{52,53,54}
311 Professional interpreter services may be in-person or remote; remote interpreter services
312 include telephone language lines, video links, and other remote systems. Health professionals
313 and other staff need to be trained on working with an interpreter and how to determine
314 whether an individual is competent to interpret.

315

316 **Domain 3.3**

** When evaluating the quality of interpreter services, it is important to consider that national standards for healthcare interpreters and a process for certification for all languages have not been established yet.

317 **Translation Services.** Patient-related written materials are translated into the most common
318 languages of the patient population.^{55,56} These materials should be evaluated for context,
319 written from the patients perspective and, when possible, originally written in the intended
320 language. Relevant patient-related materials include applications, consent forms (procedural
321 consent, research consent), participation in therapeutic trial forms, preventive and treatment
322 instructions, and patient education materials. Translated materials should be evaluated for
323 linguistic and cultural appropriateness with respect to both content and context.⁵⁷

324

325 **Domain 3.4**

326 **Health Literacy Strategies.** The need to address the literacy needs of the patient in both oral
327 and written communication, that can be an issue even if your primary written and spoken
328 language^{††} is English. Healthy People 2010 defines health literacy as the “degree to which
329 individuals can obtain, process, and understand the basic health information and services they
330 need to make appropriate health decisions.”⁵⁸ People with low health literacy tend to have
331 more problems with both written and oral communication.⁵⁹ Strategies to improve oral and
332 written communication with low literacy patients could include: 1) avoid use of medical jargon,
333 and instead use commonly understood words; 2) use audiovisual and graphic aids to
334 supplement oral and written instructions; 3) include interactive instructions by making patients
335 do, write, say, or show something to demonstrate their understanding; 4) write materials at a
336 sixth-grade level or lower; 5) pretest materials to evaluate whether they are suitable for the
337 intended audience; and 6) utilize the NQF-endorsed[™] Safe Practice “teach back” method to ask
338 each patient to “teach back” in her or his own words key information about the proposed
339 treatments or procedures for which he or she is being asked to provide informed consent.^{60,61,62}

340

341 **Domain 3.5**

342 **Knowledge of Culture and Social Context.** Having the knowledge base of cultural groups
343 with respect to traditional healing practices, health-related beliefs and cultural values, disease
344 incidence, prevalence and outcomes, as well as health disparities.^{63,64,65,66} It is the knowledge of

^{††} Primary written or spoken language is defined as the self-selected language the patient wants to communicate in with their healthcare provider.

345 the socio-demographics, migration history and other relevant socio-economic characteristics of
346 the local communities receiving care. (See also Domain Four Care Delivery and Supporting
347 Mechanism, Sub domain Clinical Encounter)

348

349 **Domain 3.6**

350 **Cultural Self Awareness.** Self-examination and exploration of one’s own cultural background.
351 This includes being cognizant, observant and conscious of similarities and differences among
352 cultural groups.⁶⁷ It also includes an awareness of our own assumptions, biases, stereotypes,
353 and prejudices with respect to individuals from other cultures.^{68,69,70} (See also Domain Four
354 Care Delivery and Supporting Mechanism, Sub domain Clinical Encounter)

355

356 **Domain 3.7**

357 **Cross-Cultural Communication Skills.** Skills to obtain culturally relevant data, such as
358 through conducting cultural assessments and culturally-based physical assessments.^{71,72,73,74}
359 Patient-based cross-cultural communication makes the patient a primary source of cultural
360 knowledge and an active participant in patient-clinician discussions.⁷⁵ It also includes skills
361 needed in “identifying and negotiating different styles of communication, decisionmaking
362 preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and
363 racism”.⁷⁶ Communicating effectively with people different from one's self is a process that
364 requires trust, awareness, sensitivity, respect, honesty, and skills.

365

366 **Domain 3.8**

367 **Family Centeredness.** Respecting the potential wish of culturally diverse groups to include
368 their family members in healthcare decisionmaking.⁷⁷ While recognizing that certain privacy
369 regulations and laws exist, organizational procedures and policies should adapt within these
370 laws and accommodate family-centered care as determined by the patient. (For example,
371 patients may actually have difficulty explicitly “asking” a provider to have their families in
372 decisionmaking, but their actions may signal their desire to do so.). Knowledge and
373 understanding the role that family play in healthcare decisions integral to delivering family-
374 centered care. This includes knowledge of culturally defined composition and roles within
375 families; skills necessary to communicate with family members with attention to age, gender,

376 etc. ; include family members in decisionmaking when requested; honor patient and family
377 perspectives and choices; and patient and family knowledge, values, beliefs and cultural
378 backgrounds are incorporated into the planning and delivery of care.

379

380

381 **Domain Four**

382 **Care Delivery Structures and Supporting Mechanisms** encompasses the delivery of care, the
383 physical environment where the care is delivered from the first encounter to the last, and links
384 to supportive services and providers.

385

386 **Domain 4.1**

387 **Clinical Encounter.** Both patients and healthcare providers bring to the healthcare encounter
388 cultural backgrounds, beliefs, practices, and languages that can effect each interaction.⁷⁸ In
389 certain instances, patients and providers could have differing understanding of what constitutes
390 appropriate care and their roles in the encounter. Also, the culture or beliefs of some patients
391 may mean they are less likely to ask questions, question the provider's care plan, or share in
392 decisionmaking.

393

394 **Domain 4.2**

395 **Physical Environment.** This includes culturally sensitive design and architecture, physical
396 environments, where the décor, artwork, posters, and literature reflect the diversity of the
397 service area.⁷⁹ It also includes appropriate signage in the major languages spoken in the service
398 area.⁸⁰

399

400 **Domain 4.3**

401 **Assessment Tools.** Tools such as environmental scans exist that help elicit culturally relevant
402 information on health beliefs, values, behaviors and practices.⁸¹ These data can be used to assist
403 with establishing a physical environment, care delivery and supporting mechanisms that are
404 culturally appropriate for the community served.

405

406 **Domain 4.4**

407 **Coordination of Care.** Includes documenting and tracking referrals to other healthcare
408 services in the continuum of care and ensuring that information on patients' cultural needs is
409 shared with other healthcare providers. Care transitions, disease management, and medication
410 reconciliation are critical components of ensuring the coordination of care is culturally
411 competent. In addition, coordination of care includes transitions back to home and family, and
412 support for palliative and end-of-life care.

413

414 **Domain 4.5**

415 **Linkages with Community and Faith Based Organizations.** Understanding and addressing
416 the context of the patient (e.g., socioeconomic status, supports/stressors, environmental
417 hazards) as an important element of cultural competence.^{82,83} It is important to identify
418 community-based organizations and faith-based organizations, such as human, social service
419 advocacy, civic, neighborhood, and religious organization, and coordinate with them to assist
420 with care delivery.

421

422 **Domain 4.6**

423 **Linkages with Alternative Medicine Providers.** Identifying patients' use of alternative
424 providers and coordinating with these providers to augment allopathic treatments and avoid
425 complications due to incompatible therapies.⁸⁴

426

427 **Domain 4.7**

428 **Health Information Technology.** New information technologies, such as electronic and
429 personal medical records, should be used to enhance and promote the delivery of culturally
430 competent care.

431

432

433 **Domain Five**

434 **Workforce Diversity and Training** is a means to providing more effective services for
435 culturally diverse populations via proactive recruitment and retention/promotion strategies. It

436 is needed to ensure diversity at all levels of the organization; it also relates to whether training
437 and development activities include state-of-the-art content in cultural competency and reflect
438 organizational commitment to cultural competence.⁸⁵

439

440 **Domain 5.1**

441 **Recruitment and Retention.** Human resource practices aimed at diversifying the workforce at
442 all levels of the organization.⁸⁶ Racial/ethnic and language concordance between patient and
443 provider has been associated with better patient experiences with care and satisfaction.^{87,88}
444 However, the current demographics of the health professions do not correspond to the
445 composition of the general workforce. For example, while African Americans and Hispanics
446 account for about 25 percent of the workforce, fewer than 12 percent of physicians and
447 therapists, and only 15 percent of registered nurses are from these two racial/ethnic groups.⁸⁹
448 This calls for proactive recruitment strategies that will result in a more diverse applicant pool.
449 Organizations should seek out alternatives to generic newspaper advertisements, search firms,
450 and other conventional and mainstream recruiting methods. Community-based and national
451 organizations and networks and publications and/or search firms that target diverse
452 populations may provide better channels for recruiting and advertising vacancies.⁹⁰
453 Historically Black Colleges and Universities, predominately Hispanic/Latino colleges and
454 universities and healthcare associations representing diverse individuals are also valuable
455 resources. Furthermore, organizational efforts aimed at improving the diversity of the
456 workforce pipeline are needed. This may include partnerships with local elementary and
457 secondary school, particularly those with a high percentage of racial/ethnic minorities, to
458 increase their interest in healthcare professions. Organizational efforts need to go beyond
459 recruitment strategies and include retention strategies – otherwise organizations can become a
460 “revolving door” for diverse employees, as they leave the organization in pursuit of better
461 opportunities or a more welcoming environment. Retention strategies include efforts to create a
462 welcoming climate for diverse populations, identifying barriers that prevent employees from
463 achieving their full potential, and providing promotional opportunities.^{91,92} Formal mentoring
464 programs, leadership development, professional development and training, work-life balance

465 and flexible benefits, and affinity groups are among the human resource retention strategies
466 that can be used.⁹³

467

468 **Domain 5.2**

469 **Training Commitment and Content.** Organizations need to ensure that managers and staff at
470 all levels of the organization receive appropriate and ongoing training in cultural competency
471 and that those efforts are evaluated.^{94,95} Training should also include strategies to assist
472 diverse staff with relating to each other. Staff training should emphasize the knowledge and
473 skills as outlined under the a) patient-provider communication; and the b) care delivery and
474 supporting domains.^{96,97} Leadership training should include content from all seven NQF-
475 endorsed domains of cultural competence. Cultural competency training can be delivered as a
476 stand-alone program or it can be integrated into other training programs. Formal training can
477 be complemented with less formal activities that develop staff knowledge about cultures and
478 languages in their hospital, such as cultural fairs and reading clubs focused on specific cultures
479 or languages.⁹⁸ This training should be conducted by qualified staff that are trained and are
480 cultural competence experts and periodically updated and repeated. The training should be
481 assessed for effectiveness and relevance so that trainings are reflective of the populations being
482 served by the organization and the needs of the staff.

483

484

485 **Domain Six**

486 **Community Engagement** refers to active outreach and the reciprocal exchange of information,
487 as well as to community inclusion and partnership in organizational decisionmaking.

488

489 **Domain 6.1**

490 **Community Outreach.** This includes collaborative relationships and partnerships with
491 community entities to understand and address the cultural needs of the communities served.⁹⁹
492 It may also include liaisons, such as community health workers where members of minority
493 communities are used to reach out to those communities.^{100,101} For example, community health

494 workers that are trained to teach others with the same chronic conditions about disease self-
495 management can be important resources.

496

497 **Domain 6.2**

498 **Community Representation in Organizational Decisionmaking.** Using formal and informal
499 mechanisms for community engagement, such as community advisory groups or committees in
500 service planning and implementation. ^{102,103}

501

502 **Domain 6.3**

503 **Community Investments.** Organizations should invest in both the infrastructure and human
504 capital of the communities in which they operate, as well as take advantage of other community
505 assets in its outreach, educational, and information gathering activities.

506

507 **Domain 6.4**

508 **Community Based Participatory Research.**[#] Actively engage in community-based
509 participatory research. Trained community advocates can educate and inform the community
510 about clinical trials and the necessity for diversity. The community and community advocates
511 should be engaged before research is proposed and developed to establish trust. The
512 community advocates should be engaged, where possible, in the design and identification of the
513 relevance of research for members of the community and plan to provide feedback on how to
514 meet their needs.

515

516

517 **Domain Seven**

[#] Community-based participatory research (CBPR) is a collaborative approach to research that combines methods of inquiry with community capacity-building strategies to bridge the gap between knowledge produced through research and what is practiced in communities to improve health. Interest is growing rapidly for academic institutions, health agencies, and communities to form research partnerships; few agreed-upon guidelines describe how to develop or evaluate CBPR proposals or what resources are required to promote successful collaborative research efforts. Community-based Participatory Research: Assessing the Evidence; Agency for Healthcare Research and Quality

518 **Data Collection, Public Accountability, and Quality Improvement (QI)** are methodologies an
519 organization uses to collect data necessary to assess its cultural competence, whether it
520 performs routine self-assessments in this regard, and whether it integrates cultural competency
521 into its public accountability and quality improvement activities.

522

523 **Domain 7.1**

524 **Collection of Patient Cultural Competence-Related Information.** Mechanisms for collecting
525 data on cultural subgroups, such as race/ethnicity, country of origin, length of stay in the
526 United States, language preferences, education, and income of patients and integrating it into
527 the information systems.^{104,105} These data are important for strategic and service planning, and
528 can be used to monitor healthcare disparities as well for quality improvement.¹⁰⁶ The Joint
529 Commission now requires collection of patients' language and communication needs in the
530 patient record.¹⁰⁷ While this information is imperative to quality improvement, it should also be
531 integrated into public reporting initiatives.

532

533 **Domain 7.2**

534 **Collection of Community Cultural Competence-Related Information.** Includes maintaining a
535 current demographic, cultural, socioeconomic, and epidemiological profile and needs
536 assessment of the communities served and using the data for strategic planning purposes,
537 quality improvement, and public reporting initiatives.^{108, 109,110}

538

539 **Domain 7.3**

540 **Quality Improvement.** Organizations integrate cultural competence into their internal QI
541 activities. QI can be viewed as an organization-wide approach to planning and implementation
542 of continuous improvement in performance. As such, QI emphasizes continuous internal
543 examination and improvement of work processes by teams of staff trained in basic statistical
544 techniques and problem solving tools and empowered to make decisions based on the analysis
545 of the data.¹¹¹ Healthcare organizations should use QI activities to address health disparities in
546 access, outcomes, or patient experiences with care.

547

548 **Domain 7.4**

549 **Accountability.** Information about cultural competency and quality of healthcare is imperative
550 in order to help make the healthcare system more accountable, to improve patient and family
551 understanding and decisionmaking, and to improve quality. Public reporting of quality data is
552 widespread^{112,113} and will continue to increase, as will pay-for-reporting and pay-for-
553 performance initiatives by the federal government, states, and private payers. The degree to
554 which patients and families are actually using this information to make decisions about their
555 healthcare is mixed.^{114,115,116}

556

557 **Domain 7.5**

558 **Assessment of Patient Experiences with Care.** Assess patient experiences with care, in their
559 own language using qualitative and quantitative methods and report this information publicly
560 with the NQF-endorsedTM assessments Hospital Consumer Assessment of Health Plans
561 (HCAHPS)[®], Ambulatory CAHPS (ACAHPS)[®] and End-stage Renal Disease (ESRD) CAHPS[®].
562 Patient assessments of care are critical since they capture firsthand experiences as patients
563 interact with the healthcare system. The CAHPS family is a set of standardized survey
564 instruments that assess patient experiences with care in various provider settings. Prior
565 research using CAHPS data documents racial/ethnic and language differences in patients'
566 experiences with care.^{117,118,119} Focus groups and personal interviews are qualitative methods
567 that can complement quantitative assessments, such as the CAHPS family, by providing more
568 in-depth information on the observed cultural differences in patient experiences with care.

569

570 **Domain 7.6**

571 **Performance Management Systems.** Include cultural competence-related measures in the
572 organizational performance management systems, such as balanced score cards, organizational
573 climate surveys, adverse events reports, and outcomes-based evaluations.^{120,121} Including these
574 measures in performance management systems elevates their importance for the institution.¹²²
575 Examples of metrics that can be incorporated are patient and human resource outcomes for
576 different cultural groups.

577

578 **Domain 7.7**

579 **Self-Assessments of Cultural Competence.** Organizations should conduct ongoing self-
580 assessments of their progress in meeting their own cultural competence strategic plan.¹²³
581 Assessments are needed at all four levels of care: system, organizational, group, and
582 individual.¹²⁴ System and organizational-level assessments provide a picture of the
583 organization’s readiness towards cultural competency by examining its structures, policies and
584 practices. Group-level assessments can provide a gauge of organizational culture and climate.
585 Individual-level assessments can assess cultural competency at the individual level.
586 Community assessments can assist with adapting to the diversity and cultural contexts of
587 individuals and communities served.¹²⁵

588

589 **Domain 7.8**

590 **Documentation of Cultural Competency Practices.** Mechanisms to document the delivery of
591 culturally competent care services, such as the provision of language services, workforce
592 diversity, referrals to alternative medicine providers and community based organizations, and
593 compliance with NQF-endorsed preferred practices. This information is important for on-going
594 self-assessments of cultural competency, as well as for public reporting of such activities.

595

596 **Domain 7.9**

597 **Documentation of Cross-Cultural Complaints and Resolutions.** Having in place mechanisms
598 to identify and resolve cross-cultural conflicts or complaints by patients.¹²⁶ Individuals from
599 diverse backgrounds are more vulnerable to face experiences where their cultural differences
600 are not accommodated or respected by the healthcare organizations. Some of the mechanisms
601 that entities can adopt to identify and resolve cross-cultural conflicts are: providing cultural
602 competence training to staff who handle complaints and grievances or other legal or ethical
603 conflict issues; providing notice in other languages about the right of each patient to file a
604 complaint or grievance; providing the contact name and number of the individual responsible
605 for the disposition of a grievance; and offering ombudsperson services.¹²⁷

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Preferred Practices for Measuring and Reporting Cultural Competency

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611

612 INTRODUCTION

613 The need for preferred practices in cultural competency for measurement and reporting is
614 urgent. Many organizations and government agencies are currently working to further the field
615 and assist healthcare providers with providing culturally competent care. However, there is no
616 consensus regarding around the central questions of: 1) What constitutes culturally competent
617 care?, 2) Who is accountable to ensure it is delivered?, 3) How do health systems and providers
618 measure cultural competency?; and 4) Does culturally competent healthcare led to improved
619 health outcomes? Without National Voluntary Consensus for Culturally Competent Care, the
620 important work that is currently being conducted will remain in silos. In order to push the field
621 forward, all stakeholders must rally around common critical competencies. Nationally
622 endorsed critical competencies around culturally appropriate care can serve as a road map for
623 the identification of a set of preferred practices and performance measures, as well as identify
624 areas requiring additional research or development. In addition, the competencies will provide
625 a structured perspective for evaluating the development, expansion, and modifications of new
626 and existing programs (and their assessments) for cultural competency.

627

628 Cultural competency should occur across the entire spectrum of healthcare delivery and
629 involves multiple providers, organizational staff, including Leadership and all settings of care.
630 The purpose of measures and preferred practices for cultural competency are to:

- 631 • improve the quality of care through cultural competency, and therefore achieve positive
632 patient outcomes through care that is safe, family- and patient- centered, evidence-
633 based, and equitable;
- 634 • provide guidance for all stakeholders by identifying the core elements and components
635 that can be used in making decisions about the delivery of culturally competent care;
636 and
- 637 • serve as the basis for quality measures, or the development of quality measures, that can
638 be used for public accountability.

639 Since measures do not exist to address comprehensive cultural competency, a set of evidence-
640 based preferred practices can serve as the building blocks for promoting high quality, cultural

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641 competent care across all practice settings and can serve as the basis for developing
642 performance measures.
643
644 The project Steering Committee has recommended a set of 45 preferred practices that are
645 suitable for implementation and address the framework domains and sub domains. Many of
646 these practices are based on published studies, or widely-accepted experiential or consensus
647 information. The preferred practices for this project were evaluated for its adequacy using
648 NQF-endorsed standard evaluation criteria for all practice evaluations and include
649 Effectiveness, Generalizability, Benefit, and Readiness;
650 *Effectiveness* – clear evidence must be presented that indicates the practice would be
651 effective in improving outcomes;
652 *Generalizability* - the practice should be able to be utilized in multiple care settings
653 and/or for multiple types of patients;
654 *Benefit* – how would the practice improve or increase the likelihood of improving patient
655 outcomes; AND
656 *Readiness* – necessary training, technology and staff required for implementation.
657

Box A – Criteria for Evaluation of Practices

Evidence of Effectiveness

There must be clear evidence that the practice (if appropriately implemented) would be effective in improving outcomes (e.g., reduced substance use). Evidence may take various forms, including:

- research studies (syntheses) showing a direct connection between the practice and improved clinical outcomes;
- experiential data (including broad expert agreement, widespread opinion, or professional consensus) showing the practice is “obviously beneficial” or self-evident (i.e., the practice absolutely forces an improvement to occur) or organization or program data linking the practice to improved outcomes; or
- research findings or experiential data from other healthcare or non-healthcare settings that should be substantially transferable.

Generalizability

The practice must be able to be utilized in multiple applicable clinical care settings (e.g., a variety of inpatient and/or outpatient settings) and/or for multiple types of patients.

Benefit

If the practice (determined to be effective) were more widely utilized, it would improve or increase the likelihood of improving patient outcomes (e.g., improved patient function). If an effective practice already is in near universal use, its endorsement would lead to little new benefit to patients.

Readiness

The necessary technology and appropriately skilled staff must be available to most healthcare organizations. For this project, opportunity for measurement also was a consideration.

659

660 **Domain One: Leadership**

661

662 **The Problem**

663 The U.S. population continues to grow, but more importantly, rapidly diversify among racial
 664 and ethnic groups.¹²⁸ By the year 2050, Hispanics and foreign-born residents are projected to
 665 make up 48 percent of the U.S. population.¹²⁹ The large shift in demographics requires changes
 666 within the healthcare system to adjust the delivery of care for these increasingly diverse
 667 populations. Such culturally competent care will become an increasingly important component
 668 to healthcare services. Culturally competent care directly affects how care is delivered and
 669 received.¹³⁰ It has become increasingly harder for people to navigate and adapt to a healthcare
 670 system that is not tailored to their needs. Patients speak many languages and have different
 671 concepts about healthcare, including beliefs and practices for disease and treatments. Although

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672 this may be a challenge to healthcare professionals who have been trained in the concepts of
673 Western medicine, the burden of navigating the complexities of healthcare should not fall solely
674 on the patient.¹³¹

675
676 Socio-cultural differences among patients, health care providers, and the health care system can
677 be viewed by health care experts as potential causes for disparities. These differences include
678 variations in patients' ability to recognize clinical symptoms of disease and illness, thresholds
679 for seeking care, expectations of care, and the ability to understand the prescribed treatment.¹⁰
680 Differences between the patient and provider can also influence providers' decision-making
681 and interactions between patients and the health care delivery system.¹³² Furthermore, a
682 patient's satisfaction with care directly affects adherence to therapy and continuity of care.¹³³

683
684 Like general quality improvement or improving patient safety, quality improvement for
685 cultural competency directly stems from the leadership and culture of a healthcare
686 organization. Healthcare providers, clinical and organizational leaders, the Board of Trustees,
687 chief executive officers (CEOs) and the community play an essential role in developing and
688 implementing cultural competency initiatives, setting organizational policy and strategy, and in
689 monitoring organizational performance.

690
691 Leadership encompasses many facets, including a commitment to diversity, awareness,
692 organizational culture, dedicated staff and resources, policies for implementation, governance,
693 and training and development.¹³⁴ Studies have shown that 98 percent of senior leaders in
694 health care management do not reflect the population they are serving.¹³⁵ This major concern
695 can be addressed by incorporating minority health care professionals. In general they would be
696 more likely to take into account sociocultural factors when organizing health care delivery
697 systems to meet the needs of minority populations.¹³⁶ Currently, community-based
698 organizations, healthcare organizations, and healthcare professionals are beginning to
699 implement strategies to address racial/ethnic disparities relevant to the population they are
700 serving.¹³⁷ Most of these adjustments include services and programs, but the most important
701 factor in providing culturally appropriate care centers on the committed involvement of leaders
702 at all levels within an organization.¹³⁸

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A commitment to culturally competent care can be reflected through organizational planning, guiding principles, and policies.¹³⁹ Organizations should also be reflective of the population they are serving.¹⁴⁰ Research continues to suggest that the cultural orientation of the medical care system is less congruent with the cultural perceptions of the patients.¹⁴¹ Leaders can improve this situation by creating an organizational culture that can serve as a model of culturally competent behavior – e.g., by designating an individual responsible for managing cultural competency programs, having formal plans demonstrating how the needs of the diverse population will be met, and providing funds for initiatives.¹⁴² Ultimately, cultural competent care must take a systemwide approach and incorporate the active involvement of leadership to ensure continued commitment for equitable care.

Preferred Practices

Sub Domain - Organizational Culture

Practice 01: Create and sustain an environment of cultural competency through establishment of leadership structures and systems or embedding into existing structures and systems.

Specifications:

- Leadership support should be visible.
- Standardized policies and procedures to facilitate cultural competency should: 1) ensure that organizational leadership is kept knowledgeable about cultural competency issues present within the organization and is continuously involved in processes to assure that the issues are appropriately addressed; 2) provide oversight and coordination of cultural competency activities; and 3) provide feedback to frontline healthcare providers about lessons learned.
- Leadership should ensure that all staff are trained in techniques of teamwork-based problem solving and management.
- Leadership structures and systems should ensure organization-wide awareness of :
1) performance gaps and promote direct accountability of leaders for those gaps; and

- 733 2) performance assets that can benefit through dissemination and diffusion
734 throughout the organization.
- 735 • Leadership should both communicate and demonstrate in their personal behavior
736 that diversity and serving diversity well is one of the values of the organization.
 - 737 • Governance boards and senior administrative leaders should be briefed regarding
738 the organization’s cultural competency practices on a regular basis to understand
739 how tightly linked they are with providing quality care and how the activities
740 overlap.
 - 741 • Governance boards and senior administrative leaders should become personally
742 involved in patient safety to comply with the practices that will constitute the first
743 step to transforming the culture of the organization.

744

745 **Practice 02:** Identify and develop informed and committed champions of cultural
746 competency throughout the organization in order to focus efforts around providing
747 culturally competent care.

748 **Specifications:**

- 749 • Focus on champions who are mid-level managers who recognize a need, hold
750 enough power to encourage change, and are capable of building support.
- 751 • Establish champions at multiple levels of the organization.
- 752 • Leadership support of the champions should be visible.
- 753 • Integrating interpreters and community outreach workers on committees
754 throughout the hospital system.
- 755 • Integrating cultural competency as a component of performance evaluations;
756 demonstrating technical skills, meeting organizational standards, and a commitment
757 to understanding patients’ cultures and improving communication skills.
- 758 • Leaders directly address the need to improve communication about cultural
759 competency through initiatives, policies and presentations and integrate into
760 ongoing projects.

761

762 **Sub Domain - Commitment to Serving a Diverse Population**

763 **Practice 03:** Reflect a commitment to culturally competent care in the vision, goals, and
764 mission of an organization and couple this with an actionable plan.

765 **Specification:**

- 766 • Publicly make available the vision, goals, and mission of the organization and the
767 action plan for implementation.
- 768 • Update the action plan at annually, at minimum.

769

770 **Sub Domain - Leadership Diversity**

771 **Practice 04:** Implement strategies to recruit, retain, and promote at all levels of the
772 organization a diverse leadership that are reflective of the demographic characteristics of
773 the service area.

774 **Specifications:**

- 775 • Establish an internal mechanism for developing strategies that involve using a
776 committee of current diverse staff for recruitment, retention and promotion decision
777 making.
- 778 • Conduct internal and external assessments on how to address the need for diversity
779 of staff.
- 780 • Engage with community leaders and specifically target and recruit from the
781 community served.
- 782 • Recruitment and selection process should focus on meeting the needs of the
783 organization's goals for culturally competent care.

784

785 **Sub Domain - Dedicated Staff and Resources**

786 **Practice 05:** Ensure that the necessary fiscal and human resources, tools, skills, and
787 knowledge to support and improve culturally competent policies and practices in the
788 organization.

789 **Specifications:**

- 790 • Leaders must consult with the care setting managers, clinical leaders, language
791 service providers, and others to identify needed fiscal and human resources to
792 appropriately meet the cultural needs of patients.

- 793 • Leadership should provide staff, at all levels, with the available time and resources
794 for training programs and practices that promote culturally competent care.
- 795 • Continued training and coaching on culturally competent care should be available
796 for new and current staff.
- 797 • Document where the fiscal support is within the organization.
- 798 • Budget line items and specific allocations for cultural competency activities and
799 programs.
- 800 • Establish and enforces organizational policies that support the allocation of fiscal
801 resources for cultural competency.

802

803 **Sub Domain - Policies**

804 **Practice 06:** Commit to cultural competence through systemwide approaches and
805 articulated by written policies, practices, procedures, and programs.

806 **Specifications:**

- 807 • Establish a committee or a body (or utilize an existing one), comprised of
808 Leadership, to ensure that cultural competency is integrated systemwide that reports
809 directly to the Board of Directors and other leaders.
- 810 • Leadership should develop and/or provide the necessary professional development
811 training to staff, including all managers, who are accountable to the public in matters
812 of legal compliance and accreditation requirements, and for the policy on cultural
813 competence.
- 814 • Leadership should ensure that cultural competency policies are consistently
815 administered and implemented across the departments with proper guidance.
- 816 • Leadership should involve diverse sectors of the community in the planning,
817 ongoing feedback and evaluation of programs and services.
- 818 • An evaluation system should be implemented to monitor and provide ongoing
819 feedback on the effectiveness of diversity and cultural competency programs and
820 strategies, including employee training sessions.

- 821 • An advisory body of stakeholders should be appointed and should meet on a
822 quarterly basis to facilitate community input and support in implementing and
823 evaluating cultural competency standards.
- 824 • Information should continuously be disseminated on updated regulatory policies,
825 regulations, and accreditation guidelines relating the requirements guiding issues of
826 culture matters to all facilities and programs.

827

828 **Sub Domain - Training and Development**

829 **Practice 07:** Actively seek strategies to improve knowledge and skills to address cultural
830 competency in the organization.

831 **Specifications:**

- 832 • Training and development could include the following content;
- 833 ○ In-depth knowledge of the causes and research surrounding (cultural
834 competence, inequities) and healthcare disparities.
 - 835 ○ Quality-improvement strategies and skills to address disparities,
 - 836 ○ Leadership skills to implement solutions and help transform organizations,
837 and
 - 838 ○ Strategies to improve the cultural competency of the organization.
 - 839 ○ Knowledge on the linkage between cultural care, improved health outcomes,
840 legal requirements and policies including the local, State and Federal
841 Standards, quality of care issues, and the importance of the skilled use of
842 qualified interpreters, and information about the programs and services
843 offered.
- 844 • Management should develop and provide training opportunities for staff and
845 senior management, as well as to physicians, nurses, allied professionals and other
846 clinicians and providers, on diversity and cultural competency.

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851 **Domain Two: Integration into Management Systems and Operations**

852 **The Problem**

853 Attaining culturally competent care depends largely on the willingness of organizations to
854 learn, adapt, and incorporate explicit strategies into its guiding mission and goals.¹⁴³
855 Appropriately addressing the healthcare needs of a diverse population involves an
856 organization's total commitment; culturally appropriate services must be integrated to ensure
857 supportive infrastructure for implementation.¹⁴⁴ Without an organizational commitment to
858 cultural competence and a plan of action, initiatives can often be overlooked by other
859 organizational priorities.¹⁴⁵ Integrating culturally competent care into management systems
860 involves strategic planning, service planning, and marketing, in addition to continuous
861 improvement systems for staff through performance evaluations and reward systems.

862
863 Strategic planning helps an organization define its structural activities, develop policies, and set
864 goals relevant to culturally appropriate services.¹⁴⁶ A key component for planning is leadership
865 support, which serves to recognize, prioritize, and drive many of the efforts needed.¹⁴⁷ Most
866 healthcare systems and structural processes are shaped and defined by leadership; with
867 adequate management systems, services continue to flourish and commitment from all staff is
868 achievable.¹⁴⁸ Strategic planning will ultimately help a healthcare organization identify,
869 monitor, and evaluate system features that may require implementing new policies or programs
870 to stay consistent with the overall mission.¹⁴⁹

871
872 Closely integrated with organizational strategies are planning services. Designing services that
873 meet the needs of the diverse patient population are vitally important and should cover all
874 elements of healthcare encounters. Examples include accurate communication between the
875 patient and provider, adapting to religious or dietary preferences, and expanding clinical hours
876 to accommodate other schedules.¹⁵⁰ In addition to planning specific services for diverse
877 communities, appropriate marketing strategies should be implemented. Marketing services to
878 the community should encompass a broad array of outlets, such as ethnically tailored
879 newspapers, common gathering areas, such as churches, and television/radio ads. A targeted
880 approach helps ensure that information is available to those who need healthcare services and

881 create opportunities for the provider, patient population, and general community to work
882 together to improve the care provided.

883

884 A separate but equally important aspect to the integration of culturally competent services is
885 sustainable support from staff. This can be achieved through many avenues, including
886 performance evaluations and reward systems. Evaluation systems are essential for
887 accountability, identifying problems, and developing an approach for making improvements.
888 Audits are also a tool utilized at some organizations to determine if the core structure of the
889 workforce is knowledgeable and represent the needs of diverse communities.¹⁵¹ One
890 management tool that is widely recognized is incentivizing behavior. Rigorous awards
891 programs such as the Malcolm Baldrige National Quality Award or the NCQA Awards
892 Program require the submission of evidence of impact as part of the application. These
893 programs require that the applicant measure and evaluate its program, and the program per se
894 thus demonstrates improvement. Striving to be recognized by an award program, thus
895 arguably could be considered to drive improvement.

896

897 Organizational policies and procedures can provide a supportive base for meeting the needs of
898 diverse populations. A supportive infrastructure is the first and most important step to
899 integrate cultural competency into management systems and operations.¹⁵²

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901

902 **Preferred Practices**

903

904 **Sub Domain - Strategic Planning**

905 **Practice 08:** Integrate into the organizational strategic plan clear goals, policies,
906 operational procedures, and management accountability/oversight mechanisms to
907 provide culturally competent services. (This preferred practice also relates to the
908 Leadership sub domains of, Policies and Commitment to Serving a Diverse Population)

909 **Specifications:**

- 910 • Strategic plan should be developed with the participation of consumers, community,
911 and staff who can convey the needs and concerns of all communities and all parts of
912 the organization affected.
- 913 • Any results from data gathering and self-assessment processes should inform the
914 development and refinement of goals, plans and policies.

915

916 **Sub Domain - Service Planning**

917 **Practice 09:** Implement language access planning in any areas where care is delivered.

918 **Specifications:**

- 919 • Language services coordinator should be a designated staff member to coordinate all
920 language service activities, should be familiar with the service needs of the LEP
921 population, the resources available in the community, and potential partners and
922 funding sources for meeting the identified needs.
- 923 • Written language plans should be developed that identify language needs and set
924 forth the entity’s strategy for meeting those needs. Having such a plan also is
925 evidence of a provider’s compliance with Title VI.
- 926 • A language service delivery plan should be developed; the manual should include,
927 but not be limited to: copies of staff interpreter job descriptions, language service
928 protocols, training modules for bilingual staff, translations of vital documents, and
929 signage.

930

931 **Sub Domain - Reward Systems**

932 **Practice 10:** Implement reward and recognition programs to recognize specific
933 individuals, initiatives and programs within your organization that promote cultural
934 competence.

935 **Specification:**

- 936 • Establish standardized evaluation criteria to assess individuals, initiatives, and
937 programs on equal par with other recognition activities and awards.

938

939 **Sub Domain - Marketing and Public Relations**

940 **Practice 11:** Market culturally competent services to the community to ensure that
941 communities who need services receive the information. (This preferred practice is also
942 applicable to the sub domain of Public Relations.)

943 **Specifications:**

- 944 • Identify a staff member(s) that is responsible for facilitating communication with
945 communities about culturally competent services.
- 946 • Use social marketing campaigns to ensure the community is aware of the healthcare
947 disparities in the area and how the organization or provider addresses them.

948

949 **Domain Three: Patient-Provider Communication**

950 **The Problem**

951 There is a mounting barrier to healthcare quality; this barrier involves communication among
952 the provider and the patient. Even when the provider and patient speak the same language,
953 their communication is generally not optimal and the patient understanding of the interaction is
954 lacking.¹⁵³ Today, approximately 49.6 million Americans speak a language other than English
955 at home and 23.3 million have limited English proficiency (LEP).¹⁵⁴ With the growing diversity
956 of the U.S. population, a dialogue on health becomes more difficult. Clear patient-provider
957 communication is essential for effective care and has a direct effect to the quality of care,
958 including recovery time and compliance.¹⁵⁵ Communication includes both verbal and non-
959 verbal; language access, interpreter services, written communication and body language.
960 Beyond language, it also involves other aspects such as personal characteristics, social attitudes
961 and values, race, ethnicity, sexual orientation, age, gender, education, and physician and mental
962 health.¹⁵⁶ More effective patient-provider communication can lead to better self-care behavior
963 as well as improvements in health outcomes.¹⁵⁷

964

965 Language barriers are often are considered to be as significant as the lack of insurance.¹⁵⁸ This
966 barrier manifests not only through spoken language, but also interpreters, translation services,
967 health literacy strategies, cultural awareness, and cross-cultural communication skills.

968 Additionally, health status is influenced not only by individual attributes such as genetics and
969 health behaviors, but also by the patient's culture.¹⁵⁹ Patients who face barriers are less likely to
970 have a usual source of care with preventive services, and they have an increased risk of

971 nonadherence to medication.¹⁶⁰ Often, those who have difficulty speaking English use
972 physician services less, and are less likely to keep follow-up appointments.¹⁶¹ Inadequate
973 communication also leads to delayed care and ultimately cost the hospital more money due to
974 malpractice settlements.¹⁶²

975
976 Legally, patients seeking services must be offered a qualified interpreter regardless of language
977 or cost, and organizations should maintain *sufficient* services and resources. Currently,
978 however, in some instances interpreter services are ad hoc, with the use of other patients, family
979 members, and nonclinical personnel. These ad hoc services usually have negative
980 consequences: reduced physician trust, lower patient satisfaction, inaccurate communication,
981 breach of patient confidentiality, and inadequate diagnosis.¹⁶³ According to one study,
982 interpreters were not used in 46 percent of the emergency department cases involving LEP
983 patients.¹⁶⁴ Also, even if services are available, many people in a service area, especially
984 individuals with LEP, may be unaware of an organization's services and never enroll in its
985 programs.

986
987 Written communication serves an equally important role as verbal communication. Materials
988 provided to patients should be translated into the common language(s) for the provider's
989 service population. Relevant information includes applications, consent forms, preventive and
990 treatment instructions, and patient education materials.¹⁶⁵

991
992 Translations must be evaluated for content, as well as reading level. In one study of informed
993 consent for surgery and other procedures, the mean educational grade level required to
994 understand consent forms was 12.6 – which is equivalent to some college.¹⁶⁶ Even the small
995 proportion of consent forms that are written at a lower grade level may well be inaccessible to
996 many people. Based on the 1992 National Adult Literacy Survey, approximately 40 to 44
997 million people in the United States are functionally illiterate, and another 50 million people
998 have marginal literacy skills. Furthermore, patients' "functional health literacy,"¹⁶⁷ resulting
999 from a lack of familiarity with healthcare terms and phrases, may be much worse than their
1000 general literacy; the Institute of Medicine estimates that 90 million (47 percent) of U.S. adults
1001 have limited health literacy.¹⁶⁸ Adding LEP on top of health literacy barriers means patients

1002 with limited literacy and LEP who undergo surgical procedures have little understanding about
1003 the risks or alternative options, and even less opportunity to intervene if an obvious error is
1004 about to occur.

1005
1006 Effective patient-provider communication also may involve integrating family and its values in
1007 standard care. Family-centered care has shown to be important for certain cultures when
1008 making healthcare decisions.¹⁶⁹ One study revealed that Korean and Mexican Americans prefer
1009 a family-centered model of care, particularly with respect to decisions about terminal conditions
1010 and treatments.¹⁷⁰ And in some cases, family members may serve as the sole decision maker
1011 even replacing the patient. A lack of accommodation may result in a non-compliant patient and
1012 a decrease in quality of care.¹⁷¹

1013
1014 Providers should be equipped with the knowledge, skills, and resources for addressing barriers
1015 within a culturally diverse population. There is a clear benefit to cultural awareness and
1016 professional training. A pilot study of second year medical students captured a baseline
1017 measure of cultural elicitation use by the students. A six-hour intervention followed and
1018 included an assessment on cultural beliefs and attitudes, reading and discussion, culture and its
1019 role in illness, and self-assessment exercises. Results of the pilot revealed that, from baseline, all
1020 subjects increased their use of cultural elicitation after the intervention and all subjects spent
1021 more time with the patient.¹⁷²

1022
1023 High-quality services are needed at all points of contact with patients with LEP, not just patient-
1024 healthcare professional communications.¹⁷³ Thoughtful and appropriate language access and
1025 adequate planning will help in assessing language needs; allow potential activities and costs to
1026 be analyzed and programs to be developed.¹⁷⁴

1027

1028 **Preferred Practices**

1029

1030 **Sub Domain - Language Access**

1031 **Practice 12:** Offer and provide language access resources in the patient’s
1032 primary written and spoken language at no cost, at all points of contact, in a
1033 timely manner during all hours of operation and provide both verbal offers
1034 and written notices informing them of their right to receive language assistance
1035 services free of charge.

1036 **Specifications:**

- 1037 • Language resources encompass competent interpreters (staff, contractors from outside
1038 agencies, remote telephonic or video interpreting services, or credentialed volunteers)
1039 and/or bilingual/multilingual clinical staff for clinical encounters, as well as
1040 bilingual/multilingual general staff as navigators for other encounters (e.g., to assist in
1041 making appointments, assist with transfers within a facility, etc.)
- 1042 • All staff providing interpreting services or care directly provided in another language to
1043 patients should be qualified, assessed, and monitored to determine competency to
1044 provide services in healthcare settings.
- 1045 • Title 6, at minimum, should guide the language access resource policies.
- 1046 • LEP individuals should be informed – in their primary language – that they have the
1047 right to free language services and that such services are readily available.
- 1048 • At all points of contact, healthcare organizations should distribute written notices with
1049 this information and post translated signage that language services are available free of
1050 charge.
- 1051 • Patient should be explicitly asked about their primary written and spoken language and
1052 the information recorded in all records; the primary language of each patient is the
1053 language in which he or she feels most comfortable in a clinical or nonclinical encounter.
- 1054 • Informing patients about language assistance services should include one or more of the
1055 following: 1) using language identification or “I speak . . .” cards; 2) posting and
1056 maintaining signs in regularly encountered languages at all points of entry; 3) creating
1057 uniform procedures for timely and effective telephone communication between staff and
1058 LEP persons; and 4) including statements about the services available and the right to
1059 free language assistance services in appropriate non-English languages in brochures,

1060 booklets, outreach materials, and other materials that are routinely distributed to the
1061 public.

1062

1063 **Practice 13:** Determine and document the linguistic needs of a patient or legal
1064 guardian at first points of contact and periodically assessed throughout the
1065 healthcare experience.

1066 **Specifications:**

- 1067 • Ask two questions: 1) “How well do you speak English?” and for those who answer
1068 “well” ask 2) “In what language do you prefer to receive your medical care?” to
1069 identify LEP patients who will benefit from language assistance.¹⁷⁵
- 1070 • Providers should take steps to introduce language access at the first points of patient
1071 contact through, for example posters and cards used by front desk staff to identify
1072 and document patients’ language needs.
- 1073 • Document the ways in which the linguistic needs of a patient or legal representative
1074 have been met by the healthcare facility or provider.
- 1075 • Telephone reception issues should be addressed to help to ensure LEP patients can
1076 effectively communicate with office staff. A bilingual staff member should generally
1077 answer the telephone; if not, an English-speaking staff member should immediately
1078 request assistance from a bilingual staff person or should use remote translation
1079 services.
- 1080 • Ensure that answering services or telephone answering machines provide
1081 information to LEP individuals, particularly after-hours callers, which may include
1082 statements in multiple languages that inform callers how to contact emergency
1083 services.
- 1084 • Create an easily accessible record of the primary language written and spoken by
1085 developing a coding system that can be used for computers and chart notations.

1086

1087 **Sub Domain - Interpreter Services**

1088 **Practice 14:** Maintain sufficient resources for communicating with patients in
1089 their primary written and spoken language through qualified/competent
1090 interpreter resources such as competent bilingual or multilingual staff, staff
1091 interpreters, contracted interpreters from outside agencies, remote interpreting
1092 services, credentialed volunteers, and others, to ensure timely and high quality
1093 communication.

1094 **Specifications:**

- 1095 • Sufficient resources encompasses competent interpreters (staff, contractors from
1096 outside agencies, remote telephonic or video interpreting services, or credentialed
1097 volunteers) and/or bilingual/multilingual clinical staff for clinical encounters, as
1098 well as bilingual/multilingual general staff as navigators for other encounters (e.g.,
1099 to assist in making appointments, assist with transfers within a facility, etc.)
- 1100 • All individuals providing interpreting services or care directly provided in another
1101 language to patients should be qualified, assessed, and monitored to determine
1102 competency for healthcare settings.
- 1103 • All bilingual/multilingual staff and providers should be assessed and monitored to
1104 determine competency.
- 1105 • Minors, family members, and friends may not be used to provide interpreting
1106 services
- 1107 • Clinicians should receive training on how to work effectively with language services.
- 1108 • Organizations should ensure that their interpreting services adhere to the National
1109 Council on Interpreting in Health Care’s “National Standards of Practice for
1110 Interpreters in Health Care” and “National Code of Ethics for Interpreters in Health
1111 Care.”
- 1112 • The facility should post and maintain a sign, similar in size and legibility to the Hill-
1113 Burton Community Service notices supplied by HHS under the provisions of 42
1114 C.F.R. '124.604(a), informing the public of the availability of interpreter services at all
1115 points of contact.
- 1116 • Children should never be used as interpreters.

1117

1118 **Sub Domain - Translation Services**

1119 **Practice 15:** Translate all vital documents into the identified threshold
1120 languages for the community that is eligible to be served.

1121 **Specifications:**

- 1122 • Threshold language is defined as a primary language spoken by 3,000
1123 people or 5 percent of the beneficiary population, whichever is lower in an
1124 identified geographic area.
- 1125 • An organization should develop a standard policy, including available resources, to
1126 ensure competent communication of vital documents that are for non-threshold
1127 documents.
- 1128 • If a vital document is not translated, a qualified interpreter should be used to
1129 translate the documents.
- 1130 • Vital documents requiring translation include, but may not be limited to:
 - 1131 ○ Therapeutic trial consent
 - 1132 ○ Signage and way-finding directions,
 - 1133 ○ Patient intake forms,
 - 1134 ○ Consent forms for, but not limited to, the following examples: medical
1135 treatment, surgery, anesthesia, inpatient psychiatric treatment, and diagnostic
1136 tests, Advance directives,
 - 1137 ○ Patient complaint forms and grievance process ,
 - 1138 ○ Letters and notices pertaining to the reduction, denial or termination of
1139 services or benefits,
 - 1140 ○ Letters or notices that require a response from the beneficiary or client,
 - 1141 ○ Documents that advise of free language assistance,
 - 1142 ○ Information on emergency health issues,
 - 1143 ○ Patient rights and responsibilities,
 - 1144 ○ Billing and financial information,
 - 1145 ○ General information on current clinical trials being conducted within the
1146 facility and opportunities to participate,

- 1147 ○ Applications for federal/state health and social services programs, including
- 1148 financial assistance,
- 1149 ○ Consents to release medical information,
- 1150 ○ Appointment reminder notices,
- 1151 ○ Key Health education materials,
- 1152 ○ HIPAA Privacy Notice.

1153

1154 **Practice 16:** Translate written materials, outside of what is considered vital,
1155 when it is determined that a printed translation is needed for effective
1156 communication.

1157 **Specifications:**

- 1158 • Organization should develop a standard policy to ensure competent communication
- 1159 and translation of documents outside of what is considered vital.
- 1160 • Items like comment and feedback cards and other materials soliciting feedback from
- 1161 patients and their families should be included in the policy.

1162

1163 **Practice 17:** Ensure that a qualified interpreter reads a document to a patient if
1164 he or she cannot read the translated document.

1165 **Specifications:**

- 1166 • An Interpreter Attestation Form shall be completed when an interpreter is
- 1167 interpreting a discussion between a patient and a physician relating to a medical
- 1168 procedure, particularly for the purpose of obtaining an informed consent for
- 1169 treatment, and/or the sight/oral translation of the written information contained on
- 1170 the informed consent form in the presence of the healthcare provider.
- 1171 • The form shall be signed by the interpreter verifying that the information was
- 1172 interpreted and attached with the consent to the medical record.

1173

1174 **Sub Domain - Health Literacy Strategies**

1175 **Practice 18:** Use “teach back” as a patient engagement tool to enhance
1176 communication between the healthcare provider and the patient during clinical
1177 encounters.

- 1178 • At a minimum, patients should be able to explain, in their everyday words, the
1179 diagnosis/health problem for which they need care and instructions for prevention
1180 and/or treatment of conditions.
- 1181 • “Teach back” should begin early in the process of patient care decisionmaking to
1182 ensure that patients have time to understand and think about their care options.
- 1183 • Questions that begin with phrases such as “I want to be sure we have the same
1184 understanding...” “Please tell me in your own words...” “This is important for your
1185 safety...” asked by healthcare professionals or interpreters will allow patients to
1186 relay or “teach back” what they understand they have been told.
- 1187 • Some organizations have a standardized approach to educating providers using a
1188 strategy that promotes adequate communication and informed consent and one that
1189 appreciates the implications of limited health literacy. They use new employee
1190 orientations and ongoing educational and peer reinforcement events to teach the
1191 process of increasing communication, which includes specifically telling the patient
1192 that to help ensure better communication, he or she needs to state in his or her own
1193 words what the provider discussed with him or her.
- 1194 • Children should also be assessed for their understanding of their condition, taking
1195 into account their individual developmental stage.

1196

1197 **Practice 19:** Communicate key information about the proposed treatments or
1198 procedures for which patients are being asked to provide informed consent.

1199 **Specifications:**

- 1200 • Ask each patient or legal surrogate to “teach back” in his or her own words,
1201 key information about the proposed treatments or procedures for which he
1202 or she is being asked to provide informed consent.¹⁷⁶

- 1203
- 1204
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- 1206
- At a minimum, patients should be able to explain, in their everyday words, the diagnosis/ health problem for which they need care; the name/type/general nature of the treatment, service, or procedure, including what receiving it will entail; and the primary risks, benefits, and alternatives.
- 1207
- 1208
- Informed consent documents for use with the patient should be written at the 5th grade level or lower and in the primary language of the patient.
- 1209
- 1210
- 1211
- Engage the patient, and as appropriate the family and other decision makers, in a dialogue about the nature and scope of the procedure for which consent is being sought.
- 1212
- 1213
- Provide a qualified medical interpreter or reader to assist patients with limited English proficiency, limited health literacy, and visual or hearing impairments.
- 1214
- 1215
- This practice encompasses both informed consent as well as assent by adolescent patients.
- 1216
- 1217
- Children should also be assessed for their understanding of their condition, taking into account their individual developmental stage.

1218

1219 **Sub Domain - Cultural Awareness**

1220 **Practice 20:** Regularly assess attitudes, practices, policies and structures of all staff as a
1221 necessary, effective and systematic way to plan for and incorporate cultural competence
1222 within an organization.

1223 **Specifications:**¹⁷⁷

- 1224
- 1225
- 1226
- 1227
- 1228
- 1229
- The assessment must be conducted in an environment that: (1) offers participants a forum to give honest statements of their level of awareness, knowledge and skills related to cultural competence; and (2) provides an opportunity for participants to share their individual perspectives in a candid manner; and (3) assures that information provided will be used to effect meaningful change within the organization.

- 1230 • The assessment must solicit and value the experiences and perspectives of patients
1231 and families who receive services.
- 1232 • Results should be used to strategically plan long- and short-term objectives to
1233 enhance the organization’s capacity to deliver culturally competent services at all
1234 levels within the organization, including: policy makers, administrators, providers,
1235 subcontractors and consumers at both the state and local level.
- 1236 • Assessment results must be shared with participants and key stakeholders in a
1237 manner that meets their unique needs.
- 1238 • Use a Quality Improvement framework to make improvement.
- 1239

1240 **Sub Domain - Family Centeredness**

1241 **Practice 21:** Include family members in healthcare decisions, when requested by the
1242 patient, when providing care for culturally diverse populations.

1243 **Specifications:**

- 1244 • Healthcare providers listen to and honor patient and family perspectives and
1245 choices.
- 1246 • Patient and family knowledge, values, beliefs and cultural backgrounds are
1247 incorporated into care planning and decision-making.
- 1248 • Healthcare providers communicate and share complete and unbiased information
1249 with patients and families in ways that are affirming and useful.
- 1250 • Patients and families receive timely, complete, accurate information in order to
1251 effectively participate in care and decision-making.
- 1252 • Patients and families are encouraged and supported in participating in care and
1253 decision-making at the level they choose.
- 1254 • Patients, families, and providers collaborate in policy and program development,
1255 implementation, and assessment; in healthcare facility design; and in professional
1256 education, as well as in the delivery of care.
- 1257

1258 **Domain Four: Care Delivery and Supporting Mechanisms**

1259

1260 **The Problem**

1261 Many potential causes contribute to healthcare disparities and the fact that culturally diverse
1262 patients have a different level of satisfaction with the care they receive. Recent studies,
1263 however, have indicated that variations in patients' health beliefs, values, preferences, and
1264 behaviors play an important role.^{178,179,180} The burden of adapting and navigating through a
1265 healthcare environment should not be placed solely on the patient, and healthcare professionals
1266 and organizations should think proactively and incorporate initiatives and activities that
1267 address the needs of a diverse population.¹⁸¹

1268

1269 Lack of culturally competent care is not an abstract concept that affects only patient perception
1270 of care. For example, data from the Robert Wood Johnson Foundation's *Expecting Success*
1271 communities indicates that a number of characteristics of healthcare providers may affect
1272 culturally diverse population's access to heart care and contribute to disparities. The factors
1273 are: market competition; the growing trend of market segmentation; the lack of dedicated
1274 resources to provide care for the uninsured; referral arrangements; and the coordination of
1275 cardiac care across multiple sites and providers.¹⁸²

1276

1277 Important variations also exist in the way that diverse populations communicate with their
1278 providers that may affect the kind of care they receive. This can include variations in patient
1279 descriptions, recognition and communication of symptoms, when they seek care, and
1280 comprehension of the prescribed management strategy and adherence.¹⁸³ Additionally,
1281 spirituality is an important yet neglected factor in healthcare, particularly among culturally
1282 diverse populations.¹⁸⁴ Up to 77 percent of patients would like spiritual/religious issues
1283 considered as part of their medical care, yet only 10 to 20 percent of caregivers discuss these
1284 issues with their patients.¹⁸⁵ Spiritually and religion are often considered a large component of
1285 culture, and as the healthcare system incorporates changes to reflect culturally competent care,
1286 the effects of religion and spirituality on patient safety and care should also be considered.

1287

1288 Providing culturally competent care means properly addressing the manner in which care is
1289 delivered, the physical environment where that care is delivered, and linkages with supportive
1290 services and providers. Without a comprehensive, holistic approach, it will be difficult to
1291 eliminate inequities in healthcare provided to minority populations.

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Preferred Practices

Sub Domain - Clinical Encounter

Practice 22: Provide resources, if requested by the patient, to allow them to access provider language information.

Specifications:

- In order to be included, providers should be assessed for language proficiency if it is not their native language.
- The resource should be in an easy to read and accessible format.
- The resource should be created by individuals with an understanding of the language and culture.

Practice 23: Develop and implement a comprehensive care plan that addresses cultural concerns.

Specification:

- Care plan should be developed with patients and their caregivers.
- The care plan should include patients and families primary written and spoken language, and note any cultural beliefs that might effects the care plan like spirituality/religion, nation of origin, and ethnicity.

Practice 24: Consider spiritual and religious beliefs that may complement or conflict with standard medical care.

Specifications:

- Organization should have specific written policies and procedures that address exceptions to standard medical care for religious and spiritual reasons (e.g., legal cases involving services such as blood transfusions).⁴
- Policies should be accepting of the benefits of spiritual/religious beliefs.

Sub Domain - Physical Environment

1323 **Practice 25:** Adapt the physical environment where the healthcare is being delivered to
1324 represent the culture of the populations who access their healthcare in that environment.

1325 **Specifications:**

- 1326 • Prominently display images, artwork, and other decor that reflects and does not
1327 offend the cultures and ethnic backgrounds of clients served.
- 1328 • Provide magazines, brochures, and other printed materials in reception areas that
1329 are of interest to and reflect the different cultures of individuals and families served.
- 1330 • When using videos, films or other media resources for health education, treatment or
1331 other interventions, ensure that they reflect the cultures and ethnic background of
1332 individuals and families served.
- 1333 • Ensure printed information disseminated takes into account the average literacy
1334 levels of individuals and families receiving services.

1335

1336 **Sub Domain - Coordination of Care**

1337 **Practice 26:** Use culturally appropriate care coordination services that take into
1338 consideration the cultural diversity of the populations seeking healthcare.

1339 **Specifications:**

- 1340 • Identify a staff person to coordinate services that reflects the community.
- 1341 • Put systems in place to track referrals and services.
- 1342 • Follow-up on referrals and services to track if they were completed.
- 1343 • Intervene with patients that are not getting the services that were referred.

1344

1345 **Sub Domain - Health Information Technology**

1346 **Practice 27:** Explore, evaluate and consider the use of multi-media approaches and
1347 information technology (HIT) to enable healthcare that is patient and family-centered
1348 and culturally tailored.

1349 **Specifications:**

- 1350 • Electronic health records should be equipped to capture care, ethnicity and primary
1351 written and spoken language.
- 1352 • When as electronic health record is used, appropriate information should be shared
1353 with patients accounting for language, cultural diversity and values.

- 1354 • Utilize multi-media or HIT that incorporates the needs of diverse populations to
1355 accommodate language, cultural diversity and health literacy.
1356 • Technology should be adaptable and available to diverse populations with different
1357 primary languages and health literacy levels.

1358
1359

1360 **Domain Five: Workforce Diversity and Training**

1361

1362 **The Problem**

1363 There is a growing evidence base that racial and ethnic concordance between providers and
1364 patients improves patients' satisfaction and compliance/outcomes.¹⁸⁶ Other evidence suggests
1365 that when providers engage in a language other than their own, rapport, quality of
1366 communication, and understanding increases.¹⁸⁷ Put simply, it is important to have the
1367 appropriate staff and resources available for serving diverse populations. Failing in these areas
1368 means a lack of quality patient care, poor compliance, misunderstandings and poor
1369 coordination of treatments. For example, research suggests that patients who are racially or
1370 ethnically diverse are more likely to have a perceived bias and often times do not follow-up
1371 when seeking treatment in the healthcare system.¹⁸⁸ A lack of cultural competence and
1372 sensitivity among providers may contribute to this problem.¹⁸⁹

1373

1374 A diverse healthcare workforce is not a panacea, but it clearly can improve access to high-
1375 quality of care for underserved individuals and increase patient satisfaction with care, expand
1376 the pool of medical professionals who may serve as policymakers or management, strengthen
1377 the medical research agenda, and more importantly advance culturally competent care. Several
1378 studies pointed to links between the racial and ethnic diversity of the healthcare workforce and
1379 healthcare quality.¹⁹⁰ For example, studies have found that when there is racial concordance
1380 between doctor and patient—e.g., when they share the same racial or ethnic background—
1381 patient satisfaction and self-rated quality of care are higher.¹⁹¹ Additionally, patient-centered
1382 and effective treatment of people of all backgrounds, requires that healthcare providers be
1383 knowledgeable about cultural belief systems, ethnic origins, non-traditional treatments, and the
1384 influence of family structures.¹⁹² Addressing such constructs of culture does not necessarily

51

1385 come from textbooks; it lends itself more to involvement in the environments of the populations
1386 being served.

1387

1388 Developing a diverse workforce that is reflective of the community and patient population
1389 involves recruitment and retention of a diverse administrative and clinical staff.¹⁹³ With the
1390 proper strategies to recruit, retain, and train staff for the provision of culturally appropriate
1391 care; patient trust will increase and overall quality of care will improve.

1392

1393 A commitment to training to address the needs of a culturally diverse population is as, if not
1394 more, important to cultural competency given the current demographics of the healthcare
1395 workforce. Difficulties in the healthcare system may range from language barriers around
1396 informed consent, to accessing services or denial of services, and outright discriminatory or
1397 culturally insensitive treatment.¹⁹⁴ Training that includes skills and knowledge that support
1398 culturally competent care should be readily available for staff, in particular those who have
1399 both clinical and non-clinical patient contact, and including senior management and
1400 administrators.¹⁹⁵ This should not be limited to language access and the ability of providers to
1401 speak with patients in their primary written and spoken language, but also include changes to
1402 the workplace environment and the availability of resources.¹⁹⁶

1403

1404 Ultimately, policies, practices, procedures, and programs addressing workforce diversity and
1405 training should be integrated systemwide so as to provide a more meaningful and effective
1406 commitment to the delivery of culturally competent care.

1407

1408

1409 **Preferred Practices**

1410

1411 **Sub Domain - Recruitment and Retention**

1412 **Practice 28:** Recruit and hire at all levels, including management levels,
1413 ethnically diverse providers and staff.

- 1414 **Specifications:**
- 1415 • Promote a system of recruitment and retention of qualified staff from diverse
- 1416 backgrounds who understand their patient cultures and communities in order to
- 1417 support an organizational culture that can better serve the community.
- 1418 • Human Resource managers should assess and report on employee promotions,
- 1419 terminations and resignations, including the use of exit interviews, to evaluate how
- 1420 well the organization is doing in the promotion and retention of a diverse work
- 1421 force.
- 1422 • Annually assess the organization’s progress in recruitment, hiring, and retention of
- 1423 qualified bicultural/multicultural employees.

1424

1425 **Practice 29:** Actively promote the retention of a culturally diverse workforce through

1426 organizational policies and programs.

- 1427 **Specifications:**
- 1428 • Adapt a personnel policy that creates create a comfortable and welcoming work
- 1429 place for(new term);
- 1430 • Mentor culturally diverse employees by senior executives;
- 1431 • Subcontract with culturally diverse health providers;
- 1432 • Tie executive compensation to steps taken to match hiring to community needs;
- 1433 • Expand on traditional affirmative action programs aimed at attracting employees
- 1434 who match the race and ethnicity of the patient populations;
- 1435 • Establish a set of principles for respectful treatment of all people;
- 1436 • Review fairness of human resource practices and compensation of all staff; and
- 1437 • Track staff satisfaction by racial and ethnic groups.

1438

1439 **Sub Domain - Training Commitment and Content**

1440 **Practice 30:** Implement training that builds a workforce able to address the cultural

1441 needs of patients, and to provide appropriate and effective services as required by

1442 federal, state and local laws, regulations, and organizational policies. (See also

1443 Leadership, Sub Domain, Policies)

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Specification:

- Recruitment and selection process should focus on meeting the needs of the organization’s goals for culturally competent care.
- Promote a system of recruitment and retention of qualified staff from diverse backgrounds who understand their patient cultures and communities in order to support an organizational culture that can better serve the community.
- Provide training opportunities to increase cultural competency skills to assist staff with responsibilities for direct patient care.
- Annually assess the organization’s progress in recruitment, hiring, and retention of qualified bicultural/multicultural employees.
- Human Resource managers should assess and report on employee promotions, terminations and resignations, including the use of exit interviews, to evaluate how well the organization is doing in the promotion and retention of a diverse work force.

Domain Six: Community Engagement

The Problem

An important element to improving the provision of culturally competent care and reducing health disparities centers on community engagement. Integrating an understanding of the community needs with community collaborations among health institutions, providers, and outreach workers can improve care quality for diverse populations.¹⁹⁷ Healthcare professionals and organizations should understand the communities in which they serve, including the social structures and environmental factors that impact health and the perceptions of healthcare.¹⁹⁸ Such community engagement is multifaceted and involves many components, such as a needs assessment, community outreach, involving community leaders in program development and decision-making processes, and community-based participatory research.

Healthcare organizations need to understand their communities, as well as their patient/consumer populations to provide quality healthcare services. For example developers

1474 of programs often are not sensitive to cultural norms and boundaries that support or hinder
1475 behaviors related to screening, early detection, and prevention.¹⁹⁹ Without an informed
1476 knowledge about communities and culture, important health and healthcare programs usually
1477 are not very successful or sustainable.²⁰⁰ Of note, data collection about *potential*, as well as
1478 current, patient populations is important, as is the utilization of as many data sources as
1479 possible, including sources outside the organization itself. Characteristics of a community
1480 change over time, so it also is critical that healthcare organizations ensure that data on their
1481 community are up to date. A demographic, cultural, and epidemiological profile of the
1482 community and a needs assessment are tools to help organizations understand their
1483 communities and can help providers and policymakers develop appropriate services and
1484 evaluate access to, and utilization of, those services.

1485
1486 A critical component to community engagement involves forming partnerships with leaders,
1487 including but not limited to spiritual and social leaders, community members and other
1488 community networks. Such partnerships can clearly have a positive impact on the health of
1489 minority populations. For example, a community partnership with the Haitian community in
1490 the Tampa Bay area resulted in more than 80 Haitian women receiving mammographies and
1491 clinical breast exams, and approximately 4,500 people receiving educational messages about
1492 breast cancer.²⁰¹ Support from community gatekeepers, such as clergy, local Haitian nonprofit
1493 organizations, and a Haitian outreach worker, helped broaden community interest and
1494 provided legitimacy and sustainability to the program.²⁰²

1495
1496 Community based participatory research (CBPR) also provides an opportunity to tackle health
1497 disparities in communities.²⁰³ An assessment of CBPR in environmental and occupational
1498 health in the United States found clear evidence that CBPR results in actions that effect
1499 community-level change.²⁰⁴ In 14 of 20 studies, CBPR led to community-level action to improve
1500 the health and well-being of the community members. Observational studies that investigated
1501 problems posed by the affected community and that incorporated qualitative methods were
1502 more likely to lead to action. The collaboration among government scientists, university
1503 researchers, and community partners emerged as a new model of CBPR partnerships that

1504 effectively integrates research and action. Community needs assessments, partnerships, and
1505 CBPR are all considered to be investments.

1506
1507 Robust community engagement has clear benefits for the patients, the healthcare community,
1508 and the greater healthcare system. A study conducted by the Trust for America’s Health found
1509 that investing \$10 per person per year in community disease prevention programs could save
1510 the United States \$2.8 billion in health costs over two years and \$16.5 billion over five years.²⁰⁵
1511 The study analyzed community-based prevention programs that promote physical activity,
1512 good nutrition, and smoking cessation. Among the findings were that community health
1513 programs could reduce the rates of diabetes and high blood pressure by 5% within two years
1514 and the incidence of some forms of cancer and arthritis within 10 to 20 years.²⁰⁶

1515
1516 Community engagement is a cornerstone to providing culturally competent care. To
1517 adequately meet the challenges of health disparities within communities, careful consideration of
1518 culture must be incorporated in all aspects of program development, message and
1519 implementation.²⁰⁷

1520

1521

1522 **Preferred Practices**

1523

1524 **Sub Domain - Community Outreach**

1525 **Practice 31:** Engage communities to ensure that healthcare providers
1526 (individual and organizational) are aware of current and changing patient
1527 populations, cultural and communication needs and provides opportunities to
1528 share resources and information.

1529 **Specifications:**

- 1530 • Use qualitative data methodologies.
- 1531 • Engage with local community-based organizations to access their data.
- 1532 • Use indirect methods like public health and census data.

- 1533 • Identify key informants and engage in interviews and focus groups to learn about
1534 shifting cultural practices of the community.

1535

1536 **Practice 32:** Collaborate with the community to implement programs with
1537 clinical and outreach components to address culturally diverse populations,
1538 health disparities and equity in the community.

1539 **Specifications:**

- 1540 • Organizations should work closely with a community advisory board.
- 1541 • Organizations should collaborate with community organizations, in particular for
1542 health education programs where they can help to raise awareness about local
1543 healthcare services.
- 1544 • Organizations should partner with the community on specific programs, and draw
1545 on the experiences and resources in the community to develop training programs,
1546 research projects, and outreach activities.

1547

1548 **Practice 33:** Utilize a variety of formal and informal mechanisms to facilitate
1549 community and patient involvement in designing and implementing and
1550 evaluating the effectiveness of cultural competency activities.

1551 **Specifications:**

- 1552 • Patients and community representatives should be actively consulted and involved
1553 in a broad range of service design and delivery activities.
- 1554 • Formal and informal mechanisms should be utilized including participation in
1555 governing boards, community advisory committees, ad hoc advisory groups, and
1556 community meetings, as well as informal conversations, interviews, and focus
1557 groups.
- 1558 • Healthcare organizations should collaborate and consult with community-based
1559 organizations, providers, and leaders for the purposes of partnering on outreach,
1560 building provider networks, providing service referrals, and enhancing public
1561 relations with the community being served.

1562

1563 **Sub Domain - Community Investments**

1564 **Practice 36:** Providers of healthcare and organizations should engage communities in
1565 building their assets as vehicles for improving health outcomes.

1566 **Specifications:**

- 1567 • Work with the community and organization decisionmakers to assess gaps in
1568 services.
- 1569 • Establish programs and services to compliment existing assets.
- 1570 • Provide stable funding streams to programs until they are sustainable through
1571 internal resources.

1572

1573 **Sub Domain - Community Based Participatory Research**

1574 **Practice 35:** Use the methodology of CBPR, when conducting research in the
1575 community, as a collaborative approach to research that equitably involves all
1576 stakeholders in the research process and fosters the unique strengths that the
1577 community brings to the process.

1578 **Specifications:**

- 1579 • Identify key opinion leaders in the community to assist with decisionmaking around
1580 research study topics and design.²⁰⁸
- 1581 • Engaging local knowledge and local theory based on the experience of people
1582 involved to improve the quality and validity of the research.²⁰⁹
- 1583 • Provide resources and possible employment opportunities for the communities
1584 involved.
- 1585 • Recognize existing community resources and building community capacity to
1586 identify and conduct research.²¹⁰

1587

1588 **Domain Seven: Data Collection, Public Accountability, and Quality Improvement**

1589

1590 **The Problem**

1591 To reduce disparities, data on the race, ethnicity, and primary language are essential. These
1592 data document where disparities exist, allow for quality improvement and monitoring progress,
1593 and provide the foundation for rewarding good performance. Data currently being captured,

1594 however, falls short of being able to meet these ends. Despite the obvious benefits and needs,
1595 the majority of hospitals, health plans, and physician practices do not routinely capture this
1596 information, and certainly not in a useable form. Even fewer link the data to quality measures
1597 or use them for quality improvement.²¹¹ Meaningful progress to achieve equity in healthcare
1598 quality cannot occur without better data on race, ethnicity, and primary language.²¹²

1599
1600 Many challenges exist to collecting race and ethnicity data, such as patient concerns that the
1601 data will exacerbate discrimination and disparities, patient suspicions about confidentiality, a
1602 need for standardized race and ethnicity codes and electronic health records, and a need for
1603 consistent data feeds from multiple providers. There also is concern that there may be
1604 unintended consequences that may worsen disparities. Recently, however, The Joint
1605 Commission released its *Hospitals, Language, and Culture (HLC)* study, which identified how the
1606 challenges associated with cultural and language are being addressed at 60 hospitals across the
1607 country. The Joint Commission found no “one size fits all” solution, but based on data gathered
1608 it states that collecting and using data is essential to developing and improving services in
1609 health care, including services developed to meet the needs of diverse patient populations.
1610 Moreover, the Joint Commission specifically calls attention to this as one of six domains in its
1611 framework, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*.²¹³

1612
1613 The IOM report *Crossing the Quality Chasm* notes that a system is high quality if it provides care
1614 that does not vary because of personal characteristics such as gender, ethnicity, geographic
1615 location, and socioeconomic status.²¹⁴ Systemic cultural competence, which includes processes
1616 to monitor and assess the quality of care and detect disparities by stratifying measures by
1617 race/ethnicity, would lay the foundation for targeted quality improvement activities.²¹⁵ In 2002,
1618 the Institute of Medicine (IOM) released the report, *Unequal Treatment: Confronting Racial and*
1619 *Ethnic Disparities in Health Care*, which found that racial and ethnic minorities presently receive
1620 lower quality of care than their white counterparts, even after controlling for factors such as
1621 insurance, socioeconomic status, comorbidities, and stage of presentation.²¹⁶ One important –
1622 though not the sole – contributor to these disparities is a lack of culturally competent care.

1623

1624 A critical component to ensure the linkage between culturally competent care and improved
1625 outcomes is the collection of race/ethnicity and primary language data from patients. We know
1626 that the quality of patient-provider relationships is important – it affects patients' adherence to
1627 treatment regimens and their satisfaction with care. Despite the knowledge of its importance to
1628 improving the delivery of culturally competent care and reducing disparities in the quality of
1629 care, the collection of race/ethnicity and language data is not systematic nor standardized.
1630 Stratifying measures by race/ethnicity and primary language will enable physicians, hospitals,
1631 healthcare systems and others to review their quality information to determine where
1632 disparities exist and act on them. Additionally, collecting race/ethnicity and primary language
1633 is an integral step if a healthcare organization wants to create a report to examine inequalities in
1634 the care provided to patients from different racial, ethnic, and language backgrounds.²¹⁷ Such
1635 a report can track areas that need improvement and areas where things are going well over time
1636 and monitor progress towards eliminating healthcare disparities.

1637
1638 Although essential, more than basic race, ethnicity, and language data need to be collected and
1639 integrated into a healthcare provider's or professional's quality improvement efforts. Current
1640 research suggests that health status is influenced not only by individual attributes such as
1641 genetics and health behaviors, but also by the physical, social, and cultural, dimensions of a
1642 person's environment.²¹⁸ Consequently, healthcare professionals and organizations need to
1643 understand their communities, as well as their patient/consumer populations to provide
1644 quality health care services. A demographic, cultural, and epidemiological profile of the
1645 community and a needs assessment are tools to help organizations and professionals
1646 understand their communities. These tools can help providers and policymakers develop
1647 appropriate services and evaluate access to, and utilization of, those services. Many people in a
1648 service area, especially individuals with LEP, may be unaware of an organization's services and
1649 never enroll in its programs. Consequently, it is important to collect data about *potential*, as well
1650 as current, patient populations and to use as many data sources as possible, including sources
1651 outside the organization itself. Because many characteristics of a community change over time,
1652 it is also critical that healthcare organizations and professionals ensure that data on their
1653 community is up to date.

1654

1655

1656 **Preferred Practices**

1657

1658 **Sub Domain - Collection of Patient Cultural Competence-Related Information**

1659 **Practice 36:** Utilize the Health Research & Educational Trust (HRET) Disparities
1660 Toolkit²¹⁹ to collect patient race/ethnicity and primary written and spoken language
1661 data from patients in a systematic, uniform manner. **(Already NQF-endorsed)**

1662 **Specifications:**

- 1663 • Use the HRET toolkit as specified. The toolkit is broken down into sections that
1664 outline the following: Who should use the Toolkit ; Why collect race, ethnicity, and
1665 primary language data; Why collect data using a uniform framework; The nuts and
1666 bolts of data collection; How to ask questions about race, ethnicity, and primary
1667 language; How to use race, ethnicity, and primary language data to improve quality
1668 of care; How to train staff to collect this information; How to inform and engage the
1669 community; How to address the communication access needs of deaf and hard of
1670 hearing populations; Available tools and resources; Answers to frequently asked
1671 questions.
- 1672 • Organizations should ensure by policies and procedures that all data are not used
1673 for discriminatory purposes.

1674

1675 **Practice 37:** Ensure that, at minimum, data on the individual patient's race and ethnicity
1676 (using the OMB categories) and primary written and spoken language are collected in
1677 health records, integrated into the organization's management information systems, and
1678 periodically update language.

1679 **Specifications:**

- 1680 • Use the OMB categories of:

1681 **OMB Ethnicity:** Hispanic or Latino; Not Hispanic or Latino.

1682 **OMB Race:** American Indian/ Alaska Native; Asian; Black/ African American;
1683 Native Hawaiian/Other Pacific Islander; White

- 1684 • Update the information annually.
- 1685 • Organizations should ensure by policies and procedures that all data are not used
- 1686 for discriminatory purposes.

1687

Sub Domain - Collection of Community Cultural Competence-Related Information

1688 **Practice 38:** Utilize the indirect data collection methodologies (e.g. geocoding, surname
1689 analysis) to characterize the race, ethnicity and primary written and spoken language of
1690 a community for service planning and conducting community-based targeted
1691 interventions.
1692

Specifications:

- 1693 • Use data to develop and implement population level interventions.
- 1694 • Identify resources for target populations.
- 1695 • Identify gaps in information and data use direct methods to fill gaps.

1696

1697
1698 **Practice 39:** Maintain a current demographic, cultural, and epidemiological profile of
1699 the community to accurately plan for and implement services that respond to the
1700 cultural and characteristics of the service area.

Specifications:

- 1701 • Healthcare organizations should regularly use a variety of methods and information
1702 sources like public health data to maintain data on racial and ethnic groups in the
1703 service area.
- 1704 • Data should extend beyond the organization’s own data, such as marketing,
1705 enrollment, and termination figures, which may provide an incomplete portrait of
1706 the potential patient population
- 1707 • Data sources such as census figures and/or adjustments, voter registration data,
1708 school enrollment profiles, county and State health status reports, and data from
1709 community agencies and organizations should be used
- 1710 • Quantitative and qualitative methods should be used to determine cultural factors
1711 related to patient needs, attitudes, behaviors, health practices, and concerns about
1712 using healthcare services as well as the surrounding community’s resources, assets,
1713 and needs
1714

- 1715 • Organizations should ensure by policies and procedures that all data are not used
1716 for discriminatory purposes.
- 1717 • Organizations should ensure through educational efforts that all patients and the
1718 community are aware of the importance of the data and the non-discriminatory
1719 policies and procedures.
- 1720 • After baseline information is obtained, the data should be updated biannually at
1721 minimum.

1722

1723 **Sub Domain - Quality Improvement**

1724 **Practice 40:** Apply a quality improvement framework to improve cultural competency
1725 and discover and eliminate disparities in care using the race, ethnicity, and primary
1726 written and spoken language collected by the institution.

1727 **Specifications:**

- 1728 • Identify NQF-endorsed™ performance measures to collect and use for quality
1729 improvement.
- 1730 • Based on national benchmarks, set organizational targets and benchmarks for
1731 performance measures.
- 1732 • Utilize performance improvement methodology and science such as rapid cycle
1733 change and Plan-Do-Study-Act cycles.

1734

1735 **Sub Domain - Accountability**

1736 **Practice 41:** Publicly report data for the applicable NQF-endorsed™ Disparities-
1737 Sensitive National Voluntary Consensus Standards for Ambulatory Care stratified by
1738 race/ethnicity and primary written and spoken language.

1739 **Specifications:**

- 1740 • As outlined in the NQF report, identify which quality measures are appropriate (a
1741 subset or all) to stratify and report on for the population served.
- 1742 • Utilize the HRET toolkit to collect the race/ethnicity and primary language data.

1743

1744 **Practice 42:** Regularly make available to the public information about their progress and
1745 successful innovations in implementing culturally competent programs (especially the

1746 NQF-endorsed preferred practices on cultural competency) and to provide public notice
1747 in their communities about the availability of this information. (See also Leadership
1748 Domain)

1749 **Specifications:**

- 1750 • Prepare an annual progress report documenting the organization's progress with
1751 implementing culturally competent practices, including information on programs,
1752 staffing, and resources.
- 1753 • Prepare and proactively distribute an annual progress report documenting the
1754 organization's progress with implementing culturally competent programs
1755 (especially the NQF-endorsed preferred practices on cultural competency).
- 1756 • The information provided should be readily accessible and community-friendly.

1757

1758 **Sub Domain - Assessment of Patient Experiences with Care**

1759 **Practice 43:** Assess and improve patient/family-centered communication on an ongoing
1760 basis.

1761 **Specifications:**

- 1762 • Use the OMB categories to collect the race, ethnicity and primary written and spoken
1763 language of the respondents.
- 1764 • The design and implementation of communication initiatives should assess the
1765 needs of patients, families, and staff.
- 1766 • Data should be used to build support for initiatives; champions should build
1767 support for new communication initiatives by presenting qualitative and
1768 quantitative data on communication needs and performance.
- 1769 • Information on model programs should be collected; site visits so successful
1770 programs should be conducted and/or published guides should be consulted.
- 1771 • At minimum, annually utilize focus groups or patient surveys to assess whether
1772 patients and their families feel patient-provider communication is effective.

1773

1774 **Practice 44:** Any surveys created by or conducted by the organization must collect race,
1775 ethnicity and primary written and spoken language and analysis and results must be
1776 stratified by race, ethnicity and primary written and spoken language.

- 1777 **Specifications:**
- 1778 • Survey materials must be translated into and conducted in threshold languages.
- 1779

1780 **Sub Domain - Documentation of Cross-Cultural Complaints and Resolutions**

1781 **Practice 45:** Ensure that conflict and grievance resolution processes are culturally
 1782 sensitive and capable of identifying, preventing, and promptly and equitably resolving
 1783 cross-cultural conflicts or complaints by patients, or between organizational staff.

1784 **Specifications:**

- 1785 • Policies should be in line with the organizations other grievance processes, such as
 1786 sexual harassment.
- 1787 • Provide complaint/grievance mechanisms to facilitate communication and problem
 1788 resolution.
- 1789 • Oversight and monitoring of the frequency and nature of cross-cultural complaints
 1790 and grievances and their resolution should occur and be an integral part of the
 1791 organization’s quality assurance program.
- 1792 • An annual report of all cultural and language access complaints should be prepared
 1793 by the champions and provided to the leadership.
- 1794 • Notices should be provided in other languages about the right of each patient to file
 1795 a complaint or grievance.
- 1796 • A staff member should acknowledge the receipt of a patient’s grievance orally or in
 1797 writing within timely working days, and will include the name and contact
 1798 information for the appropriate official.
- 1799

1800 **Table 1: Preferred Practices and Specifications Cross-walked to the Framework**

Domain	Sub Domain	Practice Number	Practice Statement
Leadership	Organizational Culture	1	Create and sustain an environment of cultural competency through establishment of leadership structures and systems or embedding into existing structures and systems.

Leadership	Organizational Culture	2	Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.
Leadership	Commitment to Serving a Diverse Population	3	Reflect a commitment to culturally competent care in the vision, goals, and mission of an organization and couple this with an actionable plan.
Leadership	Leadership Diversity	4	Implement strategies to recruit, retain, and promote at all levels of the organization a diverse Leadership that are reflective of the demographic characteristics of the service area.
Leadership	Dedicated Staff and Resources	5	Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization.
Leadership	Policies	6	Commit to cultural competence through systemwide approaches and articulated by written policies, practices, procedures, and programs.
Leadership	Training and Development	7	Actively seek strategies to improve knowledge and skills to address cultural competency in the organization.
Integration into Management Systems and Operations	Strategic Planning	8	Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services. (This preferred practice also relates to the Leadership sub domains of, Policies and Commitment to Serving a Diverse Population)
Integration into Management Systems and Operations	Service Planning	9	Implement language access planning in any areas where care is delivered.
Integration into Management Systems and Operations	Reward Systems	10	Implement reward and recognition programs to recognize specific individuals, initiatives and programs within your organization that promote cultural competence.

Integration into Management Systems and Operations	Marketing and Public Relations	11	Market culturally competent services to the community to ensure that communities who need services receive the information. (This preferred practice is also applicable to the sub domain of Public Relations.)
Patient-Provider Communication	Language Access	12	Offer and provide language access resources in their primary written and spoken language at no cost to each patient in their primary language at all points of contact, in a timely manner during all hours of operation and provide both verbal offers and written notices informing them of their right to receive language assistance services free of charge.
Patient-Provider Communication	Language Access	13	Determine and document the linguistic needs of a patient or legal guardian at first points of contact and periodically assessed throughout the healthcare experience.
Patient-Provider Communication	Interpreter Services	14	Maintain sufficient resources for communicating with patients in their primary written and spoken language through qualified/competent interpreter resources such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high quality communication.
Patient-Provider Communication	Translation Services	15	Translate all vital documents into the identified threshold languages for the community that is eligible to be served.
Patient-Provider Communication	Translation Services	16	Translate written materials, outside of what is considered vital, when it is determined that a printed translation is needed for effective communication.
Patient-Provider Communication	Translation Services	17	Ensure that a qualified interpreter reads a document to a patient if he or she cannot read the translated document.

Patient-Provider Communication	Health Literacy Strategies	18	Use “teach back” as a patient engagement tool to enhance communication between the healthcare provider and the patient during clinical encounters.
Patient-Provider Communication	Health Literacy Strategies	19	Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.
Patient-Provider Communication	Cultural Awareness	20	Regularly assess attitudes, practices, policies and structures of all staff as a necessary, effective and systematic way to plan for and incorporate cultural competence within an organization.
Patient-Provider Communication	Family Centeredness	21	Include family members in healthcare decisions, when requested by the patient, when providing care for culturally diverse populations.
Care Delivery Structures and Supporting Mechanisms	Clinical Encounter	22	Provide resources, if requested by the patient, to allow them to access provider language information.
Care Delivery Structures and Supporting Mechanisms	Clinical Encounter	23	Develop and implement a comprehensive care plan that addresses cultural concerns.
Care Delivery Structures and Supporting Mechanisms	Clinical Encounter	24	Consider spiritual and religious beliefs that may complement or conflict with standard medical care.
Care Delivery Structures and Supporting Mechanisms	Physical Environment	25	Adapt the physical environment where the healthcare is being delivered to represent the culture of the populations who access their healthcare in that environment.
Care Delivery Structures and Supporting Mechanisms	Coordination of Care	26	Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.
Care Delivery Structures and Supporting Mechanisms	Health Information Technology	27	Explore, evaluate and consider the use of multi-media approaches and information technology (HIT) to enable healthcare that is patient and family-centered and culturally tailored.
Workforce Diversity and Training	Recruitment and Retention	28	Recruit and hire at all levels, including management levels, ethnically diverse providers and staff.

Workforce Diversity and Training	Recruitment and Retention	29	Actively promote the retention of a culturally diverse workforce through organizational policies and programs.
Workforce Diversity and Training	Training Commitment and Content	30	Implement training that builds a workforce able to address the cultural needs of patients, and to provide appropriate and effective services as required by federal, state and local laws, regulations, and organizational policies. (See also Leadership, Sub Domain, Policies)
Community Engagement	Community Outreach	31	Engage communities to ensure that healthcare providers (individual and organizational) are aware of current and changing patient populations, cultural and communication needs and provides opportunities to share resources and information.
Community Engagement	Community Outreach	32	Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities and equity in the community.
Community Engagement	Community Outreach	33	Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing and evaluating the effectiveness of cultural competency activities.
Community Engagement	Community Investments	34	Providers of healthcare and organizations should engage communities in building their assets as vehicles for improving health outcomes.
Community Engagement	Community Based Participatory Research	35	Use the methodology of CBPR, when conducting research in the community, as a collaborative approach to research that equitably involves all stakeholders in the research process and fosters the unique strengths that the community brings to the process.

Data Collection, Public Accountability, and Quality Improvement	Collection of Patient Cultural Competence-Related Information	36	Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit ²²⁰ to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner. (Already NQF-endorsed)
Data Collection, Public Accountability, and Quality Improvement	Collection of Patient Cultural Competence-Related Information	37	Ensure that, at minimum, data on the individual patient's race and ethnicity (using the OMB categories) and primary written and spoken language are collected in health records, integrated into the organization's management information systems, and periodically update language.
Data Collection, Public Accountability, and Quality Improvement	Collection of Community Cultural Competence-Related Information	38	Utilize the indirect data collection methodologies (e.g. geocoding, surname analysis) to characterize the race, ethnicity and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.
Data Collection, Public Accountability, and Quality Improvement	Collection of Community Cultural Competence-Related Information	39	Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural and characteristics of the service area.
Data Collection, Public Accountability, and Quality Improvement	Quality Improvement	40	Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language collected by the institution.
Data Collection, Public Accountability, and Quality Improvement	Accountability	41	Publicly report data for the applicable NQF-endorsed TM Disparities- Sensitive National Voluntary Consensus Standards for Ambulatory Care stratified by race/ethnicity and primary written and spoken language.

Data Collection, Public Accountability, and Quality Improvement	Accountability	42	Regularly make available to the public information about their progress and successful innovations in implementing culturally competent programs (especially the NQF-endorsed preferred practices on cultural competency) and to provide public notice in their communities about the availability of this information. (See also Leadership Domain)
Data Collection, Public Accountability, and Quality Improvement	Assessment of Patient Experiences with Care	43	Assess and improve patient/family-centered communication on an ongoing basis.
Data Collection, Public Accountability, and Quality Improvement	Assessment of Patient Experiences with Care	44	Any surveys created by or conducted by the organization must collect race, ethnicity and primary written and spoken language and analysis and results must be stratified by race, ethnicity and primary written and spoken language.
Data Collection, Public Accountability, and Quality Improvement	Documentation of Cross-Cultural Complaints and Resolutions	45	Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients, or between organizational staff.

1801

1802 **PRACTICES RECOMMENDED FOR FURTHER RESEARCH**

1803

1804 A number of practices evaluated in this project met the threshold criteria of specificity, but
1805 failed to meet one or more of the other criteria. The list of practices recommended for further
1806 research is not all-inclusive (Table 2), but does include practices that hold promise, but are not
1807 mentioned in the current state of cultural competency research. These practices should be
1808 given high priority fro additional research before they are recommended for universal
1809 implementation.

1810

1811 Cultural Competency research should include, the following:

- 1812 • Methods to ascertain the successful implementation of the practices;
- 1813 • Research studies to link the implementation of practices to improved health
1814 outcomes;
- 1815 • Identification of possible unintended consequences that may arise from the use of
1816 the practices;
- 1817 • Use of oral translation and when its appropriate to use it;
- 1818 • Unintended consequences around distributing the race/ethnicity of healthcare
1819 providers;

1820

1821

1822 **RELATIONSHIP TO OTHER NQF-ENDORSED™ STANDARDS**

1823

1824 This report does not represent the entire scope of NQF work relevant to cultural competency.
1825 In 2004, NQF identified addressing healthcare disparities as a national imperative and
1826 developed a set of disparities-sensitive measures that can be used for public reporting, quality,
1827 and disparities improvement at the practice level. The panel identified a set of 35 performance
1828 measures in 8 areas. In addition, it identified a measure of experience of care that is “disparities
1829 sensitive,” comprehensive, and broadly applicable in ambulatory settings. NQF also endorsed
1830 a set of disparities sensitive measures that addresses community-level performance. The set
1831 includes 14 AHRQ Prevention Quality Indicators (PQIs) collected from hospital discharge data

1832 that cover hospitalizations that might have been avoidable if appropriate ambulatory care had
1833 been provided. NQF's *Improving Healthcare Quality for Minority Patients: Workshop Summary*
1834 explored how measurement and reporting strategies can be used to improve healthcare quality
1835 for minority patients. In May 2003, NQF published *Safe Practices for Better Healthcare*, a report
1836 documenting 30 NQF-endorsed practices that should be used universally to reduce the risk of
1837 harm resulting from processes, systems, or environments of care. In December 2003, NQF
1838 initiated a project as a follow-up to this report. The project's goal was to identify strategies for
1839 accelerating widespread adoption of the NQF-endorsed voluntary consensus standard for
1840 informed consent, Safe Practice 10 (now Safe Practice 2 after the Safe Practice 2006 Update).
1841 Safe Practice 10 stood out among the 30 practices because of its cross-cutting relevance across
1842 clinical areas, its focus on patient-centered care, and its importance to patients who are
1843 particularly vulnerable to receiving poor-quality care and to being exposed to medical errors
1844 because of communication barriers. These patients often are those with limited health literacy,
1845 which includes both those with limited English proficiency (LEP) and native English speakers
1846 who have difficulty understanding healthcare terms and concepts. The report contains a
1847 synthesis of the key barriers encountered and lessons learned by providers that adopted Safe
1848 Practice 10, including detailed evaluations of the experiences and perspectives of the
1849 early adopters, pilot adopter, and nonadopters. A separate publication, *Implementing a National*
1850 *Voluntary Consensus Standard for Informed Consent: A User's Guide for Healthcare*
1851 *Professionals*, provides a concrete tool for assisting healthcare administrators, providers,
1852 interpreters, and others in implementing and using Safe Practice 10.

1853

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1857

1858 STEERING COMMITTEE

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1925 National Health Law Program
1926 Washington, DC

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Appendix A— Commissioned Paper “A Cultural Competency Framework and Preferred Practices
for Quality Measurement and Reporting”

A Cultural Competency Framework for Quality Measurement and Reporting

Robert Weech-Maldonado, Ph.D.
Associate Professor
Department of Health Services Research, Management and Policy
University of Florida
PO Box 100195
Gainesville, FL 32610-0195
Phone: (352) 273-6080
Fax: (352) 273-6075
Email: rweech@php.ufl.edu

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Purpose

The Institute of Medicine¹ in its report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* documents the existence of racial and ethnic disparities in access to health care, as well as poorer outcomes and health status among racial and ethnic minorities. Among the strategies advocated for reducing disparities in health care is the provision of “culturally competent” care.²

The Office of Minority Health’s³ publication of standards for culturally and linguistically appropriate services (CLAS) for health care organizations (HCOs) has been a major catalyst in the development of various frameworks for cultural competence measurement.^{4,5} Despite these efforts, consensus on a specific measurement and reporting framework is lacking. In order to advance the field, national voluntary consensus on critical competencies for measuring and reporting the quality of culturally competent care is needed. From these competencies, preferred practices and performance measures can be developed and endorsed.⁶

The objectives of the paper are to propose: 1) a definition of ‘cultural competency’ in the healthcare context; 2) overarching guiding principles in assessing cultural competency; and 3) a framework for measuring cultural competency that can be used across the spectrum of healthcare settings.

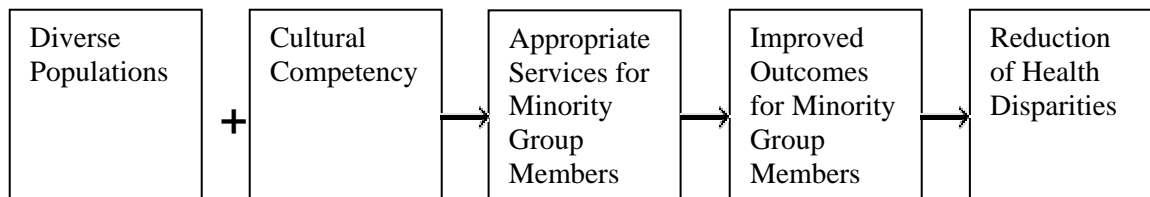
Culture and Cultural Competency

Culture can be viewed as an “integrated pattern of learned beliefs and behaviors” shared by individuals of a group that can affect styles of communication, interpersonal relationships, values, and customs.⁷ Various socio-cultural factors, such as race/ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation can influence the cultural background of an individual.

Culture is central in the delivery of health care services, since it can influence patients’ health beliefs, medical practices, attitudes towards medical care, and levels of trust.^{3, 8} Cultural differences can ultimately impact how health information is received, understood, and acted upon.⁹ Clinical barriers occur when cultural differences are not adequately addressed in health care delivery, resulting in lower access and quality of care for culturally diverse populations. As such, addressing cultural differences becomes imperative, and health care organizations are espousing cultural competency as an organizational strategy.

Brach and Fraser¹⁰ have proposed a model whereby cultural competency practices can ultimately result in a reduction of health disparities. In this model, cultural competency practices can influence the behavior of clinicians and patients, and bridge cultural gaps. This, in turn, can improve the likelihood of diverse populations receiving appropriate services and experiencing improved outcomes and a reduction in health disparities (Figure 1). For example, cultural competency can reduce barriers in clinician-patient communication, which in turn can improve access to care and ultimately outcomes of care.⁹

Figure 1: Reducing Health Disparities through the Implementation of Cultural Competency



Source: Brach and Fraser¹⁰

One of the major organizational barriers for cultural competency is the perceived impact it may have on costs. However, Brach and Fraser¹¹ have argued the business case for cultural competency. In their view, HCOs have four interrelated financial incentives for cultural competency. First, by becoming culturally competent, HCOs can increase their appeal to diverse populations, and increase their market share. This is particularly critical as the population becomes increasingly diverse. Second, cultural competence can improve the performance of HCOs in quality measures that are monitored by private purchasers, which can be particularly important in competitive markets with a large diverse population. Third, increasingly public purchasers, such as Medicaid and Medicare, are instituting cultural competency requirements in their contracts. HCOs must comply with these requirements to maintain their contracts with said public purchasers. Fourth, cultural competency has the potential to reduce costs by reducing unnecessary diagnostic testing, inappropriate use of services, and medical errors.

To date, relatively few studies have assessed the extent of cultural competency and diversity management practices of HCOs in the US.^{12, 13} Weech-Maldonado and colleagues¹² found that

hospitals in Pennsylvania have been relatively inactive with respect to cultural competency practices, and that equal employment requirements are the main driver of diversity management policy. The number and scope of cultural competency practices used were not influenced by organizational or market characteristics. A recent study of Alabama hospitals shows that while hospitals have taken initial steps to prepare for the diversifying patient population, there is still a lot more work that needs to be done before they meet the CLAS standards.¹³

Towards a Definition of Cultural Competency

While the case has been made for cultural competency from a clinical and business standpoint, the major challenge remaining is how to define and assess cultural competency. Various definitions exist on cultural competency (Table 1). One distinguishing characteristic of these definitions is the unit of analysis. While some definitions have focused on the individual or clinician level;^{14,15} others have focused on the organizational level.^{3, 6, 7, 16} Yet other definitions recognize both the individual and organizational aspects of cultural competency.^{3, 16}

All the definitions seem to agree on an ultimate outcome for cultural competency: to improve health care delivery for diverse populations. However, some of these definitions focus on the structural aspects of cultural competency, such as having the capacity or ability to address the health care needs of diverse patient populations,^{3, 7} while others describe cultural competency as a process.¹⁶ Yet other definitions use a combination of structural and process aspects, describing it as set of behaviors, attitudes, or both.¹⁷

In proposing a definition of cultural competence, we attempted to address both the individual and organizational aspects of cultural competency as well as the structural and process elements of cultural competency:

Cultural competency is the ongoing capacity of healthcare systems, organizations and professionals to provide for diverse patient populations high quality care that is family- and patient-centered and equitable.

Cultural competency is achieved through policies, learning processes, and structures by which organizations and individuals develop the attitudes, behaviors, and systems that are needed for effective cross-cultural interactions, including but not limited to socio-cultural factors such as race/ethnicity, nationality, language, gender, socioeconomic status (SES), immigrant status, physical and mental ability, sexual orientation, religion, health literacy, age, and occupation.⁸ These factors can be conceptualized as cultural group identities. Individuals' affiliations to cultural groups are complex, with individual differences based on the group identity profile and strength of the group identities.¹⁸ For example, a second generation Hispanic of higher SES will differ from a recent immigrant Hispanic of lower SES in terms of its group identity profile as well as the strength of the group identities. These differences will affect an individual's interactions with the health care system.

High quality care implies state-of-the-art care based on evidence-based clinical practices. According to the Institute of Medicine's (IOM)¹⁹ "equity" aim for health system improvement, quality of care should not differ because of socio-cultural factors. Family centeredness implies respecting the desire of culturally diverse groups to include their family members in healthcare

decision making.¹⁰ The care is patient-centered when clinicians treat each patient as an individual, within the context of his or her care.²⁰⁻²¹ This requires a partnership among clinicians, patients, and families to ensure that health care decisions take into account patient preferences.

Guiding Principles for Cultural Competency

Guiding principles for measuring and reporting cultural competency quality provide broad themes and direction that promote standardized measurement and reporting, drive practice improvement and measure development, and support implementation. The guiding principles are intended to be overarching and / or cross-cutting all (or multiple) domains of the framework presented in the next section. There are five principles that guide the development of the proposed cultural competency framework.

Principle 1. Multi-Level Approach

Cultural competency should be viewed as a multi-level approach with assessments and interventions needed at the system, provider organization, group, and individual levels.

Cultural competence has generally been viewed as pertinent to individual clinical interactions. However, this view fails to recognize that “clinicians will become culturally competent only with the support and/or encouragement of the health systems in which they participate.”¹⁰ “Cultural competence should be considered as much of a function of the organization as it is a result of the interactions between providers and patients.”²²

Four levels of care can be identified with each requiring a different set of measures of and interventions for cultural competency: 1) system- as represented by a health care or managed care entity that oversees a number of owned or affiliated provider organizations; 2) provider organization- the entities that provide direct services to the patient, such as clinics, hospitals, or nursing homes; 3) group- includes formal departmental and cross-departmental teams; 4) individual- people involved directly or indirectly in the delivery of care.^{5, 23}

Principle 2. Viewed as a Process and Continuum

Cultural competency should be viewed as an ongoing process of organizational transformation in a continuum from early to later stages of development.

For health care organizations to become more culturally competent they will need to engage in a change process of organizational transformation. This entails an organizational culture change from a monoculture, or culture that “accepts only one way of doing things and one set of values and beliefs” to a pluralistic environment, or an environment that accepts and integrates people from diverse cultural backgrounds.²⁴

This change process has been described as a continuum from early to later stages of development. For example, Tirado²⁵ proposes a five-stage model of organizational change: culturally resistant, culturally unaware, culturally conscious, culturally insightful, and culturally versatile. Similarly, Dreachslin²⁶ proposes a five-stage change model from affirmative action to valuing diversity: discovery, assessment, exploration, transformation, and revitalization.

Principle 3. Systems Approach

Successful implementation of cultural competency initiatives to achieve high-quality, culturally competent care requires an organizational commitment towards a systems approach.

Successful implementation of cultural competency requires an organizational commitment towards a systems approach.^{27, 28} In this approach, the HCO is viewed as a system comprised of interrelated and interdependent subsystems, such as patient care, ancillary services, professional staff, financial, informational, physical, and administrative subsystems.²⁹

Related to systems thinking is the open systems perspective that views organizations interacting with their environment to secure resources, process them, and produce some type of output. To survive, it is critical that organizations respond to the demands of their environment to ensure a continuous inflow of resources.³⁰ For HCOs, the community is the major resource supplier. Therefore, HCOs have to adapt to the changing community needs to ensure their survival.

Cultural competency should not be conceived as a stand alone, point-in-time effort pertinent only to clinical interactions. Rather, HCOs should strive towards a systems approach where cultural competency practices are integrated throughout their management and clinical sub-systems. Furthermore, HCOs should engage their communities in meaningful participation in the organization's decision making and power structures.

Principle 4. Diversity Management

Addressing both organizational and clinical aspects in managing diversity and the needs of both a diverse workforce and patient population are important factors in culturally competent care.

The cultural competency and diversity management literatures have had different focuses with respect to diversity issues. The cultural competency literature has had a clinical orientation with a focus on patient-clinician interactions, while the diversity management literature had an organizational orientation with a focus on workforce issues. However, these differences are becoming increasingly less distinct as both camps agree on the importance of both to cultural competency.¹² For example, it is increasingly recognized that organizations need strategies aimed at recruiting and retaining a diverse workforce, as well as staff training and development in cross-cultural communication skills to enhance cultural competency.

Principle 5. Continuous Improvement

*Cultural competency should not be viewed as an endpoint but rather organizations should strive for continuous improvement.*³¹

Continuous improvement in cultural competency represents an ongoing process whereby organizations: 1) determine cultural competency goals in the context of its strategic plan; 2) assess individual, group, and organizational baseline performance to determine gaps in performance; 3) develop interventions to close the gaps in performance; and 4) reassess performance to determine the effectiveness of the interventions. For example, in designing cultural competency training, the organization should determine goals for its training in the context of its strategic plan, measure current performance against needs, design training to

address the gap, implement the training, assess training effectiveness, and strive for continuous improvement.²⁷

Framework for Measuring and Reporting Cultural Competency Quality

Standardized measurement and reporting of cultural competency requires identification of a comprehensive framework that delineates the core competencies that comprise high-quality, culturally competent care. The framework consists of seven core competencies or domains of cultural competency and their respective sub-domains (Table 2). From this framework, preferred practices can be identified and/or mapped to, and from those practices, measures can be developed.

Domains

Seven primary domains are recommended:

8. **Leadership** recognizes that organizational leaders, including clinical leaders, administrative leaders, and the Board of Trustees, play an essential role in developing and implementing of cultural competency activities, in setting organizational policy and strategy, and monitoring organizational performance.
9. **Integration into Management Systems and Operations** focuses on whether cultural competency is integrated throughout all management practices of the organization.
10. **Patient-Provider Communication** addresses all communication between the patient and clinicians as well as support staff.

11. **Care Delivery and Supporting Mechanisms** encompasses the delivery of care, the physical environment of where the care is delivered, and links to supportive services and providers.
12. **Workforce Diversity and Training** can be viewed as a mean to providing more effective services for culturally diverse populations via human resource proactive recruitment and retention strategies to ensure diversity at all levels of the organization, and it also relates to whether training and development activities include state-of-the-art content in cultural competency and reflect organizational commitment towards cultural competency.
13. **Community Engagement** refers to active outreach, as well as community inclusion and partnership in organizational decision-making.
14. **Data Collection, Public Accountability, and Quality Improvement** means whether the organization collects data necessary to assess its cultural competency, whether it performs routine self-assessments in this regard, and whether it integrates cultural competency into its public accountability and quality improvement activities.

Sub-domains

Each of the seven proposed domains also includes specific sub-domains that further articulate the core competencies of high-quality, culturally competent care, as follows:

1. **Leadership**

- a. Commitment to Diversity - cultural competency activities are most effective when the organization's governing board and top management embraces cultural competence and communicates this support throughout the organization.^{32,33}
- b. Organizational Culture - a culture that is inclusive and values cultural differences. Organizational leaders are instrumental in setting organizational culture.³⁴ Inclusive signifies that the organization's decision making processes include diverse points of views from within and outside the organization. When an organization values diversity it is shown through its practices, structures and policies.
- c. Leadership Diversity – leadership at all levels of the organization, including the Board of Trustees, reflects the community diversity.⁴ Leadership diversity increases the likelihood that the needs of a diverse workforce and patient population are taken into account in organizational decision making processes.⁹ However, minorities have traditionally faced barriers, or a “glass ceiling” effect, that have excluded them from upper management positions.¹⁸ As such, HCOs need proactive human resource strategies aimed at diversifying the leadership ranks and breaking the glass ceiling.
- d. Dedicated Staff and Resources - an organization shows its commitment to cultural competency by dedicating resources and designating staff for cultural competence activities. Dedicated resources can be shown by budgeting resources for cultural competency activities.^{4,35} Dedicated staff can include an executive level staff member, department or office that focuses on multicultural and/or linguistic issues. This can be instrumental in coordinating organization-wide initiatives and monitoring progress towards cultural competency goals.^{32,35}

- e. Policies - formal policies that address cultural competency issues, such as recruitment and retention of a diverse workforce, language services, and training and development.^{4,35} Policies “express an organization’s intentions and provide a blueprint for action”.³⁶ These internal policies should be in conformity with external regulatory and statutory policies.
- f. Training and Development - training and development of leaders at all levels of the organization, including the Board of Trustees, on cultural competency issues.⁴ Leadership participation in training and development sends a signal to organizational members of its commitment to cultural competency.

2. **Integration into Management Systems and Operations**

- a. Strategic Planning - the strategic planning process includes environmental scanning, asset and needs assessment of the communities served, and formulation of goals related to cultural competency.³ Strategic goals reflect the organizational priorities for resource use and deployment.
- b. Performance Evaluation - job descriptions and performance evaluation systems include criteria related to cultural competency.^{3,4} This evaluation process should include assessments of patient and family experiences with care. This results in accountability for meeting cultural competency goals.
- c. Reward Systems - managers and staff are rewarded for meeting cultural competency goals.⁴ Incentives help align the organizational members’ goals with those of the organization. Thorndike’s law of effect states that behavior or performance that is reinforced tends to be repeated.³⁷

- d. Service Planning - organizations design their services taking into account the needs of their diverse patient populations. This includes all elements of the healthcare encounter from admission to discharge with the ultimate goal of improving access to care for all patients.⁸ Examples include expanding clinical hours to accommodate community work patterns, adapting to ethnic or religious dietary preferences, and allowing for large families visiting or staying with hospitalized patients.^{8, 35}
- e. Marketing- organizations promote and market their services through a variety of media that reaches out to diverse populations, including ethnic newspapers, television news programs, and radio stations.³⁵ Marketing should also emphasize the availability of language services, such as interpretation and translation services. A related concept is that of social marketing where HCOs use marketing principles to design a social-change strategy aimed at reducing high-risk behaviors or encouraging healthy behaviors.^{38 39} An example of social marketing is using the media for a public health campaign to reduce smoking.
- f. Public Relations - raise public awareness of cultural competency activities and progress in meeting goals.^{3, 4} This can include a statistical annual report on patient demographics, interpreter use and availability, translated materials, staff training in cultural competency, and survey results of patient experiences with care. This can serve as a marketing tool while enhancing the organization's image among diverse communities.

3. Patient-Provider Communication

- a. Interpreter Services - high quality interpreter services are needed at all points of patient contact to improve provider and staff communication with patients of limited

English proficiency. Accurate communication increases the likelihood of receiving appropriate care.^{3,9,35} Language concordant encounters have better communication, interpersonal processes, and outcomes than language discordant encounters,⁴⁰⁻⁴⁴ However, the limited supply of bilingual providers has led health care organizations to use interpreter services to bridge language gaps. When evaluating the quality of interpreter services, it is important to distinguish between professional and ad-hoc interpreters.² Ad-hoc interpreters are “individuals whose primary job function in the health care setting is something other than interpretation and includes the patient’s family members, friends, clinic staff, or even fellow patients”.⁴⁵ On the other hand, professional interpreters are “those individuals whose sole function in the health care setting is to interpret”.⁴⁵ Prior research has shown the effectiveness of professional interpreters compared to ad-hoc interpreters.⁴⁶⁻⁴⁸ Professional interpreter services may be in-person or remote. Remote interpreter services include telephone language lines, video links and other remote systems. Regardless of the type of interpreter used, interpreters should have proficiency in both languages, mastery of medical terminology in both languages, memory skills, ability to negotiate a three-way conversation, and basic knowledge of cultural aspects that can influence health. Bilingual providers should be proficient in the target language, including knowledge of medical terminology.²

- b. Translation Services - patient-related written materials are translated into the most common languages of the patient population.^{3,4} Examples of relevant patient-related materials include applications, consent forms, preventive and treatment instructions, and patient education materials. Translated materials should be evaluated for

linguistic and cultural appropriateness with respect to both content and context.⁴⁹

Linguistically appropriate translated materials are conceptually and technically equivalent to the source language. Technical equivalence refers to similarity in grammar and syntax, while conceptual equivalence refers to the absence of differences in meaning and content between the source and translated documents.

Weidmer et al. have proposed a translation process that involves: 1) obtaining two independent forward translations; 2) conducting a review of translation by a separate bilingual reviewer; and 3) reconciling translations by committee (forward translators and bilingual reviewer) consensus.⁵⁰ Culturally appropriate translated materials reflect the cultural assumptions, norms, values, and expectations of the target population.⁵¹ Qualitative methods, such as focus groups and cognitive interviews, are particularly useful in assessing the cultural appropriateness of translated materials.⁴⁹

- c. Health Literacy Strategies- addressing the literacy needs of the patient in both oral and written communication.² Healthy People 2010 defines health literacy as the “degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions”.⁵² People with low health literacy tend to have more problems with both written and oral communication.⁵³ Several strategies have been suggested for health care professionals to improve oral and written communication with low literacy patients:⁵⁴⁻⁵⁶ 1) avoid use of medical jargon, and instead use commonly understood words; 2) use audiovisual aids to supplement oral and written instructions; 3) include interactive instructions by making patients do, write, say, or show something to demonstrate their understanding (teach back method); 4) write materials at a sixth-grade level or

- lower; and 5) pretest materials to evaluate whether materials are suitable for the intended audience.
- d. Knowledge of Culture and Social Context - having the knowledge base of cultural groups with respect to traditional healing practices, health-related beliefs and cultural values, disease incidence, prevalence and outcomes, as well as health disparities.⁵⁷⁻⁶⁰ It should include also an awareness of the historical context that may explain the way different groups interact with the health care system.⁸ One example is the relationship between the Tuskegee Syphilis Study and mistrust of health care professionals among African Americans. However, care must be exercised that this cultural knowledge does not lead to or reinforce stereotyping.⁸ Rather this knowledge should be used in the context of patient-centered care and effective cross-cultural communication skills.⁶¹
- e. Cultural Awareness - self-examination and exploration of one's own cultural background. This includes an awareness of our own assumptions, biases, stereotypes, and prejudices with respect to individuals from other cultures.⁵⁸⁻⁶⁰
- f. Cross-Cultural Communication Skills - this includes skills to obtain culturally relevant data, such as those used in conducting cultural assessments and culturally-based physical assessments.^{58-60, 62} It also includes skills needed in “identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism”.⁸ Patient-centered cross-cultural communication makes the patient a primary source of cultural knowledge and an active participant in the patient-doctor negotiation.

- g. Family Centeredness - respecting the desire of culturally diverse groups to include their family members in healthcare decision making.¹⁰

4. Care Delivery and Supporting Mechanisms

- a. Physical Environment- this includes culturally sensitive design and architecture, physical environments, where the décor, artwork, posters, and literature reflects the diversity of the service area.⁴ It also includes appropriate signage in the major languages spoken in the service area.³
- b. Assessment Tools- use of tools to elicit culturally relevant information on health beliefs, behaviors and practices.⁴ These data can be used to assist with establishing a physical environment and care delivery that are culturally appropriate for the community served.
- c. Coordination of Care- includes documenting and tracking referrals to other health care services in the continuum of care (from ambulatory to long-term care), and ensuring that information on patients' cultural and linguistic needs is shared with other health care providers. Coordination of care includes managing the transition back to home, nursing home or other institutional care, and supporting palliative and end of life care.
- d. Linkages with Alternative Medicine Providers - identifying patients' use of alternative providers and coordinating with these providers to augment allopathic treatments and avoid complications due to incompatible therapies.¹⁰
- e. Linkages with Community Based Organizations – understanding and addressing the context of the patient (e.g., socioeconomic status, supports/stressors, environmental hazards) as an important element of cultural competence.^{4, 8} It is important to identify

community-based organizations, such as human, social service, and religious organizations, and coordinate with them to assist with care delivery.

- f. Health Information Technology- new information technologies, such as electronic and personal medical records, should be used to enhance and promote the delivery of culturally competent care.

5. Workforce Diversity and Training

- a. Recruitment - human resource practices aimed at diversifying the workforce at all levels of the organization.⁴ Racial/ethnic and language concordance between patient and provider has been associated with better patient experiences with care and satisfaction.^{2, 8} However, the current demographics of the health professions do not correspond to the composition of the general workforce. For example, while African Americans and Hispanics account for about 25 percent of the workforce, fewer than 12 percent of physicians and therapists, and only 15 percent of registered nurses are from these two racial/ethnic groups.³⁶ This calls for proactive recruitment strategies that will result in a more diverse applicant pool. As such, organizations “need to find alternatives to generic newspaper advertisements, search firms, and other mainstream recruiting methods. Community-based and national health organizations and networks as well as publications and search firms that target diverse populations may provide better channels for recruiting and advertising vacancies”.³ Furthermore, organizational efforts aimed at improving the diversity of the workforce pipeline are needed. This may include partnerships with local elementary and secondary schools, particularly those with a high percentage of racial/ethnic minorities, to increase their interest in the health care professions.

- b. Retention - organizational efforts need to go beyond recruitment strategies and include retention strategies. Otherwise organizations can become a “revolving door” for diverse employees, as they leave the organization in pursuit of better opportunities or a more welcoming environment. Retention strategies include efforts to create a welcoming climate for diverse populations, identifying barriers that prevent employees from achieving their full potential, and providing equitable promotional opportunities.^{3,9} Formal mentoring programs, professional development and training, work-life balance and flexible benefits, and affinity groups are among the human resource retention strategies that can be used.³⁶
- c. Training Commitment - organizations need to ensure that managers and staff at all levels of the organization receive appropriate and ongoing training in cultural competency.^{3,4}
- d. Training Content- staff training curriculum should emphasize the knowledge and skills as outlined under the a) patient-provider communication; and the b) care delivery and supporting domains.^{4,9} In addition, staff training should include strategies to assist a diverse staff with relating to each other. Leadership training should include content from all seven domains of cultural competence. Cultural competency training can be delivered as a stand-alone program or it can be integrated into other training programs. Formal training can be complemented with less formal activities that develop staff knowledge about cultures and languages in their hospital, such as cultural fairs and reading clubs focused on specific cultures or languages.³⁵ These trainings should be conducted by qualified staff that are trained in cultural

competence, and should be periodically updated and repeated. The trainings should be assessed for effectiveness and relevance in meeting the cultural needs of patients.

6. **Community Engagement**

- a. **Community Outreach** - this includes collaborative relationships and partnerships with community entities to understand and address the cultural and linguistic needs of the communities served.^{35,63} It may also include liaisons, such as community health workers where members of minority communities are used to reach out to those communities.^{4,10} For example, community health workers that are trained to teach others with the same chronic conditions about disease self-management.
- b. **Community-Based Participatory Research** – actively engage in community-based participatory research (CBPR). Community-based participatory research (CBPR) has been defined as a “collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change”.⁶⁴ By engaging in CBPR, HCOs enable the generation of actionable knowledge that can be used to address the most pressing health needs of the populations served.⁶⁵
- c. **Community Representation in Organizational Decision-Making** - using formal and informal mechanisms for community involvement, such as community advisory groups or committees in service planning and implementation.^{3,4}

- d. Community Investments- organizations should invest in both the infrastructure and human capital of the communities served, and should take into account the community assets in its outreach, education, and information gathering activities.

7. Data Collection, Public Accountability, and Quality Improvement

- a. Collection of Patient Cultural Competence-Related Information- mechanisms for collecting data on cultural subgroups, such as race/ethnicity, language preferences, education, and income of patients; and integrating these data into the information systems.^{3,4} These data are important for strategic and service planning, and can be used to monitor health care disparities as well as for quality improvement.⁷ The Joint Commission now requires collection of patients' language and communication needs in the patient record.³⁵
- b. Assessment of Patient Experiences with Care – assess patient experiences with care in their own language using qualitative and quantitative methods. Patient assessments of care are critical since they capture firsthand experiences as patients interact with the healthcare system. The Consumer Assessments of Healthcare Providers and Systems (CAHPS) is a set of standardized survey instruments that assess patient experiences with care across provider settings. Prior research using CAHPS data has shown racial/ethnic and language differences in patients' experiences with care.^{66,67} Focus groups and personal interviews are qualitative methods that can complement quantitative assessments, such as CAHPS, by providing more in-depth information on the observed cultural differences in patient experiences with care. These data can be used for quality improvement purposes.⁷

- c. Documentation of Cross-Cultural Complaints and Resolutions- having in place mechanisms to identify and resolve cross-cultural conflicts or complaints by patients.³ Individuals from diverse backgrounds are more vulnerable to face experiences where their cultural differences are not accommodated or respected by the HCO. Some of the mechanisms that HCOs can adopt to identify and resolve cross-cultural conflicts are: “providing cultural competence training to staff who handle complaints and grievances or other legal or ethical conflict issues; providing notice in other languages about the right of each patient/consumer to file a complaint or grievance; providing the contact name and number of the individual responsible for the disposition of a grievance; and offering ombudsperson services”.³
- d. Documentation of Cultural Competency Practices- mechanisms to document the delivery of culturally competent care services, such as the provision and timeliness of language services, workforce diversity, referrals to alternative medicine providers and community based organizations. This information is important for on-going self-assessments of cultural competency, as well as for public reporting of such activities.
- e. Collection of Community Cultural Competence-Related Information- this includes maintaining a current demographic, cultural, socioeconomic and epidemiological profile and needs assessment of the communities served and using the data for strategic planning purposes, quality improvement and public reporting initiatives.^{3, 4,}
- f. Performance Management Systems - include cultural competence-related measures in the organizational performance management systems, such as balanced score cards, organizational climate surveys, adverse events reports, and outcomes-based

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- evaluations.^{3, 35} Examples of metrics that can be incorporated are patient and human resource outcomes for different cultural groups. Including these measures in performance management systems elevates their importance for the institution.²⁸
- g. Self-assessments of Cultural Competence-organizations should conduct ongoing self-assessments of their progress in meeting cultural competence goals.³ Assessments are needed at all four levels of care: system, provider organization, group, and individual.⁸ System and provider organizational-level assessments provide a picture of the organization's readiness towards cultural competency by examining its structures, policies and practices. Group-level assessments can provide a gauge of organizational culture and climate. Individual-level assessments can assess cultural competency and cross-cultural skills at the individual level.
- h. Quality Improvement - organizations integrate cultural competence into their quality improvement (QI) activities. QI can be viewed as an organization-wide approach to planning and implementation of continuous improvement in performance. As such, QI "emphasizes continuous examination and improvement of work processes by teams of organizational members trained in basic statistical techniques and problem solving tools and empowered to make decisions based on the analysis of data".⁶⁸ Health care organizations can use QI activities to address health disparities in access, outcomes, or patient experiences with care.

Conclusion

The Office of Minority Health's CLAS standards have been a major catalyst in the development of various frameworks for cultural competence measurement. Despite these efforts, consensus

on a specific measurement and reporting framework has been lacking. Standardized measurement and reporting of cultural competency requires identification of a comprehensive framework that delineates the core competencies that comprise high-quality, culturally competent care. This paper achieved three major goals. First, we proposed a definition of cultural competence that addresses both the individual and organizational aspects of cultural competency, as well as the structural and process elements of cultural competency in healthcare. Second, we established five guiding principles that are intended to be overarching and/or cross-cutting all (or multiple) domains of the proposed framework. Finally, we proposed a framework consisting of seven core competencies or domains of cultural competency: 1) leadership; 2) integration into management systems and operations; 3) patient-provider communication; 4) care delivery and supporting mechanisms; 5) workforce diversity; 6) community engagement; and 7) data collection, public accountability, and quality improvement. Each of the seven proposed domains also includes specific sub-domains that further articulate the core competencies of high-quality, culturally competent care. From this framework, preferred practices and performance measures can be developed and endorsed by the National Quality Forum.

Table 1
Definitions of Cultural Competence

Author	Definition	Citation
Betancourt et al. 2002: V 7	“The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs”	Curtis et al. 2007 ²⁷ Larson 2005 ⁶⁹
Betancourt et al. 2003: 297 ⁸	“Understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations.”	
Brach and Fraser 2000: 183 ¹⁰	“An ongoing commitment or institutionalization of appropriate practice and policies for diverse populations	Curtis et al. 2007 ²⁷ Dreachslin and Myers 2007 ²⁸ Weech-Maldonado et al. 2002 ¹²
Cooper and Roter 2003: 554 ¹⁴	“The ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences”	
Cross et al. 1989: 13 ¹⁷	“A set of congruent behaviors, attitudes, and policies, that come together in a system, agency, or among professionals, and enable effective work in cross-cultural situations”	Anderson et al. 2003 ⁹ Brach and Fraser 2000 ¹⁰ Brach et al. 2006 ³² Hobgood et al. 2006 ⁶² Lewin Group, 2002 ⁴ Moxley et al. 2004 ⁷⁰ Ngo-Metzger et al. 2006 ² Wilson-Stronks and Galvez 2007 ³⁵ Zambrana et al. 2004 ⁷¹
MCF 2004 ⁷²	“ The ability to transform knowledge and cultural awareness into health and/or psychosocial interventions that support and	

Author	Definition	Citation
	sustain healthy client-system functioning within the appropriate cultural context”	
Kim-Godwin et al. 2001: 920 ⁵⁹	“A complex integration of cultural knowledge, cultural awareness or sensitivity, attitudes, cultural skills, and cultural encounters”	
OMH 2001: 5 ³	“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”	Anderson et al. 2003 ⁹ Hobgood et al. 2006 ⁶²
Romeo 2007: 206 ¹⁶	“A learning process that enables individuals and organizations to function effectively in the midst of cultural difference”	
Sandars and Ewart 2005: 2 ¹⁵	“A set of behaviors and attitudes that enable professionals to work effectively in cross-cultural situations”	
Schim et al. 2007 ⁷³	“A behavioral construct encompassing actions taken in response to cultural diversity, awareness, and sensitivity”	
Williams 2007: S55 ⁷⁴	“A set of academic, interpersonal, and clinical skills developed to help individuals increase their understanding of differences and similarities within, among, and between groups”	

Table 2
Framework for Measurement and Reporting of Cultural Competency

Domain	Sub-Domains
Leadership	Commitment to Diversity Organizational Culture Leadership Diversity Dedicated Staff and Resources Policies Training and Development
Integration Into Management Systems and Operations	Strategic Planning Performance Evaluation Reward Systems Service Planning Marketing Public Relations
Patient-Provider Communication	Interpreter Services Translation Services Health Literacy Strategies Knowledge of Culture and Social Context Cultural Awareness Cross-Cultural Communication Skills Family Centeredness
Care Delivery and Supporting Mechanisms	Physical Environment Assessment Tools Coordination of Care Linkages with Alternative Medicine Providers Linkages with Community Based Organizations Health Information Technology
Workforce Diversity	Recruitment Retention Training Commitment Training Content
Community Engagement	Community Outreach Community-Based Participatory Research Community Representation in Organizational Decision-Making Community Investments
Data Collection, Public Accountability, and Quality Improvement	Collection of Patient Cultural Competence-Related Information Assessments of Patient Experiences with Care Documentation of Cross-Cultural Complaints and Resolutions Documentation of Cultural Competency Practices Collection of Community Cultural Competence-Related Information Performance Management Systems Self-Assessments of Cultural Competence

Domain

Sub-Domains

Quality Improvement

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