Cultural Competency: Dealing with Disparate, Underserved, and Vulnerable Population in Your Practice

Transcript from Live Webinar

Wednesday, June 27, 2018

Judith S.: Good afternoon, my name is Judith Singletary, and thank you for joining us to discuss Cultural Competency, Dealing with Disparate, Underserved, and Vulnerable Populations in Your Practice.

I'll start by providing some context and background on the topic of cultural competence. In 1999, Congress requested that the Institute of Medicine, IOM, assess the extent of racial and ethnic disparities in healthcare, assuming insurance status, and the ability to pay for care were the same. IOM was asked to identify potential sources of these disparities, including the possibility that overt or subtle biases or prejudice on the part of healthcare providers might actually affect the quality of care for minorities. And they were also asked to suggest some intervention strategies. The committee reviewed more than 100 studies and concluded that disparities exist in many disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, mental health, and that disparities are found across a range of procedures, including some routine treatments for common health problems.

The committee's recommendations for reducing racial and ethnic disparities in healthcare included increasing awareness about disparities among the public, healthcare providers, insurance companies, and even policymakers.

This webinar is designed to explore the importance of culture, and the intersection of culture, competence and delivering care in the primary medical home setting. At the end of the webinar, participants will be able to define both culture and cultural competence, and understand the importance of adopting an intersectional approach to cultural competence in person and family engagement, which recognizes the experience of multiple social locations - including race and ethnicity, social class, sexuality, gender, age, as being central to patient and family health beliefs, behaviors, needs, and perceptions.

You'll also learn that multiple social locations in life and social context are critical to cultural competence, and key in the way that health-related messages and meanings are framed. You'll also learn how to integrate intersectional cultural competency into your practice. We'll discuss the importance of providing culturally sensitive care in the

primary healthcare setting. And lastly, we're going to discuss available resources that can help.

The content of today's webinar is divided into four parts. Part one covers key terms and concepts, and consists of defining those terms relative to culturally competent care. Part two, practice assessment, addresses key components of a culturally competent practice, which can also be used as a proxy for a high level practice assessment. Part three reviews actions that your practice can take to improve cultural competence. And part four provides a snapshot of practical cultural competence resources.

So, let's start with some key terms and concepts. Before we can discuss cultural competence, however, it's important to understand what is meant by culture. Culture's been defined as an integrated pattern of learned beliefs and behaviors that can be shared among groups. It includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs.

Culture's also shaped by multiple influences including race and ethnicity, nationality, language and gender. But, it also extends to socioeconomic status, physical and mental ability, sexual orientation, and occupation, among other factors that play a vital role in the patient/provider relationship, as well as in the health outcome of patients. Importantly, culture can influence whether patients follow illness prevention measures or whether they accept treatment at all.

In thinking about cultural competence, a person first has to fully understand what his or her own views and practices are, in order to fully understand the ways, the views, and the culture, of other people. According to the government agency SAMHSA, Substance Abuse and Mental Health Services, cultural competence is the ability to interact effectively with people of different cultures. It refers to a trait in which a person is able to coordinate, work, or interact with other people that are of different cultures and social backgrounds.

The National Center for Cultural Competence at Georgetown University Center for Child and Human Development describes the six stages of what is considered a continuum in infusing cultural competence into healthcare delivery practices. So, let's start with stage one. Stage one represents cultural destructiveness. In this stage, it's characterized by attitudes and practices, and policies and structures that are actually destructive to a cultural group.

Stage two is cultural incapacity. This stage reflects the lack of capacity systems in organizations necessary to effectively respond to the needs and interests of diverse groups. This can also include subtle messages that certain groups aren't valued or even welcome.

The third stage is cultural blindness. This stage focuses on the philosophy of fairness that views and treats people as if they're all the same. This philosophy, however, can be problematic 'cause people are different, and they have different needs, and they deserve approaches that acknowledge and celebrate those differences, while also

addressing their needs. In fact, cultural blindness negatively influences systems and policies by encouraging assimilation, ignoring cultural strengths and fostering institutional attitudes that, in effect, blame consumers or patients often for their own circumstances.

The fourth stage is cultural pre-competence. So, this stage highlights a growing awareness of strengths, as well as areas for improvement to respond effectively to culturally and linguistically diverse populations.

Stage five, the target stage for healthcare providers, is cultural competence. In this stage, acceptance and respect for culture becomes consistently demonstrated in policies and structures and practices, attitudes. This can include an organization's commitment to, say, human and civil rights, to hiring practices that reflect a diverse workforce, and increased efforts to improve service delivery, for racial, ethnic, and cultural groups.

Lastly, in stage six, cultural proficiency, culture is held in high esteem and is used as a foundation to guide all endeavors. Organizations that do this successfully continue to add to their knowledge base. They often support and mentor other organizations, maybe in their communities, and those organizations are ones that are also seeking to improve their own cultural competence.

The U.S. Department of Health and Human Services provides a blueprint, so to speak, to advance health equity, improve quality, and to help eliminate healthcare disparity, through what's called its national, culturally, and linguistically appropriate service standards, known by its acronym CLAS. The principle standard is to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, are responsive to preferred languages, health literacy, and other communication needs. Populations under this standard include people with disabilities, limited English proficiency, and low health literacy, as well as racial and ethnic minorities and sexual and gender minorities.

So, the CLAS standards are organized by three distinct domains. The first is governance, leadership and the workforce. So, these standards focus on organizational governance and leadership that promote CLAS and health equity, including recruitment of culturally and linguistically competent leadership and workforce, and training and education for culturally and linguistically competent governance, leadership and workforce.

The second domain, communication and language assistance, focuses on accessibility to language assistance, guidance for providing language assistance, assessment of individuals providing language assistance, the provision of different types of materials in print and multimedia, and health literacy.

The third and last domain, engagement, continuous improvement and accountability, focuses on CLAS-based organizational goals and policies, organizational assessment and measurement, data collection, community involvement and engagement, and CLAS-based conflict resolution and communication of progress in CLAS.

So, let's move on to part two of today's discussion, practice assessment, which builds on the key terms and concepts we reviewed in part one. In this section, I'll present a series of questions for you to reflect on, having to do with the extent of which cultural competence is integrated into your practice. It might help to have paper or maybe your tablet ready to jot down the areas that you believe are not being addressed by your practice.

Let's begin with some general questions about cultural competence, relative to your practice. For instance, what have been facilitators to fostering cultural competence? What have been barriers to fostering cultural competence? And, what actions can be taken to overcome those barriers in your practice? Does your intake form include questions about language preference, disabilities, pronoun preference, sexual orientation, and gender identity? And when introducing yourself to patients, do you ask the patient their preference for how they'd like to be addressed? With regard to demographics, does your practice and staff reflect the community it serves? And, how does your practice train and educate staff for delivering culturally and linguistically competent care?

In terms of communication and language assistance, how does your practice provide language assistance to patients with language, hearing, or sight impairment? You'll want to think about, does your practice ensure that patients understand their follow-up instructions? And, are your patient education materials designed with large fonts and culturally appropriate images, and low-literacy copy in languages that are going to accommodate your patients' preferences or needs? And in thinking about engagement, continuous improvement, and accountability, does your practice have established community partnerships? And, how are you actually collecting the data about health?

We can move on to part three, and in this part we'll review specific actions that you can consider for building a cultural competent practice. First, it's important to seek leadership that models the tenets of cultural competence. Next, you'll want to regularly review and update organizational policies and practices to make sure that they reflect the CLAS standards. It's important that you know your practice demographics, so that you can hire staff that reflects the population you serve. And also create intake forms that capture relevant cultural practices, gender identity, and pronoun preference. You'll also want to make sure you'll provide cultural competent training to staff, and that you hire qualified bilingual staff. It's also important to use remote telephone or video interpreter services as an alternative strategy to help with communication if needed.

An intersectional approach to cultural competence considers the multiple social statuses that interact to shape patients' health views, their experiences and behaviors. So, a framework for a person in family engagement, in that framework it's going to be important that engagement in the care experience is both mutual and sustained, and that interactions are authentic and intentional. While important, consideration must extend beyond recognition of social determinants of health to include patient preferences, strengths, beliefs, culture, and importantly, the lived experience. We must recognize that individuals may hold multiple social statuses or social locations in life and that these statuses are experienced simultaneously. They're mutually reinforced. They're self defining and fluid, and should be considered together. What's more,

persons and families hold both disadvantaged and advantaged statuses that either directly or indirectly impact the health experience.

As important as our covering social determinants of health, studies have also identified the full range of interlocking factors affecting the health experiences of vulnerable groups. For example, quantitative studies have examined combined effects of race and gender and impact on health. While, many qualitative studies have examined the health effects of discrimination and powerlessness compounded for those with multiple devalued social location, like race and minority and disability.

Other steps to building a cultural competent practice include maintaining current, accurate data regarding patient race, ethnicity, and language preference. And utilizing community partnerships to help recruit diverse staff and to help with planning data collection and the design of service delivery.

So, how do you get started implementing cultural competence in your practices? In part four, we'll touch on a few resources to help you put in place some of the actions that were presented in part three. Here are three resources to help you strengthen cultural competent behaviors in your primary care practice. First, Health and Human Services provides a free online course, A Physician's Practical Guide to Culturally Competent Care. You can also download the CLAS standards toolkits. And CMS's Office of Minority Health offers Building an Organizational Response to Health Disparities: A Practical Guide to Implementing the National CLAS Standards. You can also contact Quality Insights for support and a range of educational tools and materials, using the email addresses and phone numbers provided here.

This ends today's discussion on cultural competence. Please don't hesitate to forward any questions to Quality Insights. I'd like to thank you for your attention and have a wonderful remainder of your day.

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