

# From the Experience of Public Hospitals and Health Systems



Prepared by:

**The National Public Health and Hospital Institute  
Washington DC**

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# **Serving Diverse Communities in Hospitals and Health Systems**

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# **Serving Diverse Communities in Hospitals and Health Systems**

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*The views presented in this report are those of the National Public Health and Hospital Institute and are not necessarily those of the U.S. Department of Health and Human Services.*

# Table of Contents

<b>Acknowledgments .....</b>	<b>4</b>
<b>Executive Summary .....</b>	<b>5</b>
<i>Key Findings .....</i>	<i>Error! Bookmark not defined.</i>
<i>Recommendations .....</i>	8
<b>Project Overview.....</b>	<b>9</b>
<i>Case Studies of Culturally and Linguistically Appropriate Healthcare Practices.....</i>	11
<i>CEO Focus Group .....</i>	16
<i>Toolkit .....</i>	17
<i>Recommendations to Strengthen Culturally and Linguistically Appropriate Services in Safety Net Institutions.....</i>	20
<b>Case Studies.....</b>	<b>24</b>
<i>Boston Medical Center .....</i>	25
<i>Community Health Network of San Francisco/San Francisco General Hospital Medical Center.....</i>	34
<i>Denver Health.....</i>	39
<i>Harborview Medical Center .....</i>	43
<i>Hennepin County Medical Center .....</i>	51
<i>Memorial Healthcare System.....</i>	56
<i>NYCHHC-North Brooklyn Health Network/ Woodhull Medical &amp; Mental Health Center.....</i>	61
<i>Parkland Health &amp; Hospital System.....</i>	67
<i>University of Medicine and Dentistry of New Jersey – University Hospital .....</i>	71
<b>Focus Group Summary .....</b>	<b>76</b>
<b>Proposed Toolkit Content and Development .....</b>	<b>85</b>
<b>Sample of Home Page Design for Toolkit.....</b>	<b>90</b>
<b>Appendix A: Interview Guides for Case Study Research.....</b>	<b>92</b>
<b>Appendix B: 2003 NAPH Leadership Forum on Serving Diverse Communities .....</b>	<b>98</b>

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# **Executive Summary**

***Serving Diverse Communities in Hospitals and Health Systems***  
**Sponsored by the DHHS/Office of Minority Health**

**Executive Summary**

For major public hospitals and health systems across the country, providing health care in a culturally competent manner is crucial to quality of care, patient satisfaction, successful staff training and recruitment, and the financial viability of safety net institutions. Far from being a supplemental activity, cultural and linguistically appropriate practices are a fundamental part of the mission of these organizations. The DHHS Office of Minority Health (OMH) contracted with the National Public Health and Hospital Institute (NPHHI), the research and education affiliate of the National Association of Public Hospitals, to produce a compendium of best practices, or "models that work," in the area of cultural competence. The framework for this work was the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, and criteria established by the OMH.

In order to identify promising practices, NPHHI reviewed the literature on culturally and linguistically appropriate health care services. We also collected information on toolkit design and reviewed sample toolkits in the health care field, including those specifically related to cultural competence. Finally, we interviewed senior staff at most of our 100 member hospitals and health systems to learn about the work that was going on in the field.

We found a wide range of practices in our member institutions that varied considerably in terms of scope, use of data and technology, and the extent to which the culturally and linguistically appropriate services were an integral part of the institution's operations. Our most striking finding was the extent to which public hospitals and health systems have undertaken the provision of culturally and linguistically appropriate services despite resource constraints because it is central to their mission. We also found that many hospital leaders among the NAPH membership are extremely committed to the principles embodied in providing culturally and linguistically appropriate care and are searching for lessons and tools to translate these principles into effective practice.

This report, *Serving Diverse Communities in Hospitals and Health Systems*, presents the most significant and applicable strategies from the various programs and approaches currently underway in NAPH hospitals and health systems. The report presents findings and lessons learned in the form of the following deliverables:

- Case studies of nine NAPH member institutions that illustrate significant programs, policies, or strategies in the provision of culturally and linguistically appropriate health care services;
- Findings from a focus group of chief executives at a number of NAPH public hospital and health systems on the leadership components required to develop and maintain effective culturally and linguistically appropriate health care;

- A prototype web-based toolkit designed to assist providers in planning, implementing and sustaining a culturally competent health care delivery operation in a public hospital setting; and
- Recommendations to OMH to strengthen culturally and linguistically appropriate services in safety net institutions.

Senior leaders play a crucial role in setting an organization's tone and level of commitment to providing culturally competent care to the patient populations served. In a focus group held in Washington, DC, in November 2002, NAPH CEOs underscored the belief that all patients are to be treated with respect and as effectively as possible in order for culturally and linguistically appropriate health care services to be successful. Culturally and linguistically appropriate health care services should be outcome-focused and ultimately result in equal health outcomes for all in the community served by the hospital or health system.

### *Case Studies: Key Features*

- **Boston Medical Center** presents an executive strategy for leading a public hospital renowned for providing culturally and linguistically appropriate health care services.
- In accordance with the policies of the Department of Public Health, culturally competent care at the **Community Health Network of San Francisco General** provides a framework for all aspects of hospital operations and community health programs.
- At **Denver Health** the leadership is strongly committed to supporting research in the area of health care disparities and incorporates cultural competence as a strategic priority linked to all organizational activities.
- **Harborview Medical Center** expands and supplements health care and language access for diverse patient populations via its International Medicine Clinic, EthnoMed web-based clinical tool, and Community House Calls/Caseworker Cultural Mediator Program.
- **Hennepin County Medical Center** demonstrates a commitment to serving culturally and linguistically diverse communities through support of a large interpreter services department and through leadership's incorporation of specific objectives into its strategic plan.
- **Memorial Healthcare System** has partnered with two other health systems to create a provider service network to serve local Medicaid recipients, and has launched a community-based clinical and community relations campaign targeted at the local Latino population.
- **New York City Health & Hospital Corporation/Woodhull Medical and Mental Health Center** has developed and implemented model programs of care and improved customer service for diverse and LEP populations.



- At **Parkland Health & Hospital System** cultural competence is an "everyday value" as evidenced by the health system's extensive interpreter services program and the infrastructure systems created to ensure that patient needs are being met.
- At **UMDNJ-University Hospital** four key operational areas demonstrate the impact that leadership has in implementing culturally and linguistically appropriate services: strategic planning, staff recruitment and training, customer service and patient satisfaction, and community outreach.

### *Recommendations*

- Public hospitals and health systems need support to develop data systems that will provide timely, accurate metrics to monitor performance in providing culturally and linguistically appropriate care.
- Technical assistance is needed to develop measures for evaluating the efficacy of strategies to serve culturally and linguistically diverse populations.
- In order to facilitate the dissemination of lessons learned, a practical administrative and programmatic toolkit should be developed in the area of culturally and linguistically appropriate services in hospitals and health systems that focuses on implementation strategies for senior leaders, program administrators, and clinicians.
- More effective coordination is needed among the Office of Minority Health's unfunded standards and guidelines, the requirements of directives monitored by the DHHS Office of Civil Rights, and the current funding mechanisms administered by DHHS.

# **Project Overview**

***Serving Diverse Communities in Hospitals and Health Systems***  
**Sponsored by the DHHS Office of Minority Health**

**Project Overview**

For major public hospitals and health systems across the country, providing health care in a culturally competent manner is crucial to quality of care, patient satisfaction, successful staff training and recruitment, and the financial viability of safety net institutions. Far from being a supplemental activity, culturally and linguistically appropriate practices are a fundamental part of the mission of these organizations. U.S. public hospitals and health systems have long been the “health care providers of first resort” for arriving immigrant groups of virtually every ethnic and language background. These institutions have become laboratories for the processes of social, economic, and demographic change. Out of necessity, programs demonstrating linguistic, clinical, educational, and administrative competencies have been developed and modified to meet the needs of diverse and vulnerable patient populations.

Confronted with the issues raised by rapid change in a community, NAPH member hospitals and health systems have responded to these challenges despite operating in an environment characterized by overburdened and constrained financial reimbursement mechanisms. Lacking sufficient resources, public hospitals and health systems serve their culturally and linguistically diverse patient population with a variety of innovative practices, many developed by entrepreneurial leaders and staff. Increasingly, however, these institutions have recognized the importance of effective management and program systems to better serve their culturally and linguistically diverse patient populations.

The DHHS Office of Minority Health (OMH) contracted with the National Public Health and Hospital Institute (NPHHI), the research and education affiliate of the National Association of Public Hospitals, to produce a compendium of promising and effective practices, or “models that work,” in the area of cultural competence. The framework for this work was the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, and criteria established by the OMH. To identify promising practices, NPHHI reviewed the literature on culturally and linguistically appropriate health care services. We also collected information on toolkit design and reviewed sample toolkits in the health care field, including those specifically related to cultural competence. Finally, we interviewed senior staff at most of our 100 member hospitals and health systems to learn about the work that was going on in the field.

We found a range of practices at NAPH institutions that varied considerably in terms of scope, use of data and technology, and the extent to which culturally and linguistically appropriate services were an integral part of the institution’s operations. Our most striking finding was the extent to which public hospitals and health systems have undertaken the provision of culturally and linguistically appropriate services, despite resource constraints, because it is central to their mission. We also found that many hospital leaders among the NAPH membership are extremely committed to the principles embodied in providing culturally and linguistically appropriate care, and are searching for lessons and tools to translate these principles into effective practice.

The case studies, the focus group summary, the toolkit outline, and recommendations to OMH all represent multi-faceted approaches and strategies for planning, organizing, and providing quality health care for diverse populations based on the experience of NAPH members. The administrative, programmatic, and clinical strategies described in this project are intended as models that can be adapted by other providers within their own unique environments and organizational structures.

This report, *Serving Diverse Communities in Hospitals and Health Systems*, presents the most significant and applicable strategies from the various programs and approaches currently underway in NAPH hospitals and health systems. The report presents findings and lessons learned in the form of the following deliverables:

- Case studies of nine NAPH member institutions that illustrate significant programs, policies, or strategies in the provision of culturally and linguistically appropriate health care services;
- Findings from a focus group of chief executives at a number of NAPH public hospital and health systems on the leadership components required to develop and maintain effective culturally and linguistically appropriate health care; and
- A prototype toolkit designed to assist providers in planning, implementing and sustaining a culturally competent health care delivery operation in a public hospital setting.

### ***Case Studies of Culturally and Linguistically Appropriate Healthcare Practices***

Beginning in the fall of 2002, NPHHI conducted a series of in-depth discussions with clinical, administrative and operational managers in many of our member facilities across the country. NPHHI interviewed multiple key staff at these member institutions, solicited information about promising practices in the area of culturally and linguistically appropriate practices, and reviewed literature from these organizations on strategic initiatives related to diversity and to cultural competence. These discussions revealed extensive work across NAPH member institutions in the area of cultural competence and substantial variation in policies, procedures, and practices.

From these discussions we selected nine sites as the subject of case studies that would illustrate promising practices in various cultural competence initiatives in the public hospital settings. The nine sites selected for this report have integrated their cultural competence practices into their clinical and administrative procedures. NPHHI selected the case studies according to: (1) examples of interesting work and promising practices in cultural competence that we identified through our phone interviews and literature review; (2) an institution's established track record integrating cultural competence practices into its clinical and administrative procedures; (3) geographical representation, and (4) size of the institution and the level of diversity within the patient population.

## Case Study Format

As the interviews progressed with our member institutions, it became apparent that the programs at the various sites could be organized under five domains: leadership, organizational infrastructure, staff development and training, interpreter services, community relations and outreach. The information presented in each case study follows a similar format. Each case study presents background information on an institution and the communities that it serves, a brief overview of the information contained in each case study, and descriptions of the culturally and linguistically appropriate practices found at each institution. Contact information for the individuals that we interviewed is listed at the end of each case study.

The five domains are not discrete categories. However, a number of programs and practices might fit under more than one domain. Following is a description of each domain and examples from the case studies to illustrate the types of initiatives that fall within each domain.

### Leadership

Senior leaders play a crucial role in setting an organization's tone and level of commitment to providing culturally competent care to the patient populations served. Programs and initiatives may succeed or fail on the basis of support from one or more senior leaders. Senior management's role in this area is essential to initiating, integrating, and assuring culturally competent practices throughout the institution's programs and operations.

A key role of the senior leadership is to provide all staff members with the tools they need to effectively communicate and treat their diverse patient populations including: (1) a clear and unambiguous understanding of their institution's goals, policies, and values regarding the provision of culturally and linguistically appropriate care; (2) training and human resources development activities that support and promote cultural competence practices; and (3) high-quality and easily accessible interpreter and translation services. Senior leaders are also responsible for providing the infrastructure, financial, and morale-building supports necessary for staff to acquire these tools.

The leadership domain includes a range of initiatives, plans and programs developed or supported by the leadership at case study sites, including strategic plans and objectives (recruitment and retention plans to enhance workforce diversity, eradication of health disparities, improved patient satisfaction), articulated executive leadership principles, participation in research studies to determine organizational efficacy around cultural competence, top-down institutional assessments and audits, collaborations with other institutions/organizations that enhance care to underserved populations, language incentive programs for bilingual staff, and customer service and patient satisfaction research and benchmarking.

Examples include:

1. Denver Health's creation of three task forces to operationalize the CLAS standards, and its participation in AHRQ's study on the impact of race and ethnicity on the access, use, and outcomes of care as part of a collaborative to assess the capacity of integrated delivery systems to contribute to research in this area;
2. UMDNJ's strategic goal to develop the relationship between the community and cross training of employees; establishment of hiring targets as part of the strategic planning process to ensure a diverse workforce; and
3. Memorial Healthcare System's leadership in establishing the South Florida Community Care Network, a provider service network for Medicaid recipients.

### Organizational Infrastructure

Infrastructure includes information systems that collect, manage and analyze data, monitor and evaluate community demographics, and gauge utilization; mechanisms to access and obtain meaningful community input on service needs; and systems to effectively assess organizational capacities, strengths, and weaknesses (e.g., monitoring/evaluation tools, quality improvement mechanisms, and customer satisfaction benchmarking). Infrastructure also refers to policies and procedures that provide staff with a clear understanding of their institution's goals and values regarding the provision of culturally competent care and individual staff responsibilities; financial incentives and formal recognition of staff who provide culturally competent care; and the financial resources and budget allocations necessary to develop and provide these tools.

Examples include:

1. The "balanced scorecard" used at Boston Medical Center to track progress in six areas of organizational performance.
2. The use of EthnoMed, a web-based clinical tool that contains medical, cultural, and community information about limited English proficient (LEP) immigrant groups living in the Seattle area at Harborview Medical Center.
3. A needs assessment conducted by the interpreter services program at Parkland Health and Hospital System which, among other objectives, monitors interpreter use and productivity on an ongoing basis. Part of this assessment includes a medical record sticker system that records the type and length of interpretation provided.

### Staff Development and Training

Staff development and training refer to workforce training and education programs on the use of interpreters and on health and cultural issues specific to various patient populations. Staff development and training also includes language classes or classes and certification programs in medical interpretation, new employee orientation programs, mandatory classes on cultural diversity for management, and aspects of the organizational infrastructure that support staff development and training.

Workforce training and education are essential to the successful implementation of culturally and linguistically appropriate services. At many institutions staff are encouraged to participate in training programs by financial incentives or recognition programs. At a number of our sites, staffs are trained on scheduling software to make the use of interpreters more efficient. The personnel training and development initiatives described in the case studies reinforce “doing well for the patient,” rather than “meaning well.” Finally, effective staff development and training make explicit the link between organizational practices, the quality of patient care and improved health outcomes.

Examples include:

1. Boston Medical Center’s Division of Organizational Development and Training/Human Resources Department, which offers more than 80 workshops and provides an annual cultural diversity training required by all management staff.
2. NYCHHC-North Brooklyn Health Network (NBHN)/Woodhull Medical & Mental Health Center’s Medical Interpreter’s Skills Training Program, which collaborates with the NBHN Training and Patient Relations Department and the Center for Immigrant Health at the NYU School of Medicine.
3. State and federal funding received by the University of Medicine and Dentistry of New Jersey (UMDNJ) targeted to developing a medical interpreter curriculum that can be used as a best practice model in health care institutions throughout New Jersey.

### Interpreter Services

Interpreter Services refers to the provision of interpretive services for LEP patients and includes the following: access to trained interpreters; scheduling practices that maximize availability and proximity of interpreters; clinics that are conducted in the languages of the primary patient populations; the use of curriculum or training programs for interpreters and staff; the availability of signage, administrative documents and health education material written in the languages of the primary patient populations; and the use of technology to facilitate interpretation between patients and staff or to monitor and track interpreter usage.

Accurate and effective communication between patients and staff is the most fundamental component of the health care encounter. Language barriers frequently lead to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. Federal mandates require health systems to inform patients that they have the right to free language services and to ensure that such services are readily available. Effectively serving diverse populations requires that interpreter services be available and provided by trained and competent bilingual staff or medical interpreters, and that written materials be available and translated in a manner that accurately and appropriately conveys the substance of the document or sign being translated.

Examples from the case studies include:

1. Community Health Network of San Francisco/San Francisco General Hospital’s pilot test of video conferencing designed to expand the pool of interpreters by sharing interpreters among San Francisco area hospitals.

2. Hennepin County Medical Center's Interpreter Services department, which employs 42 full-time interpreters who respond to language requests in more than 60 languages and which maximizes interpreter usage through creative scheduling practices and language-specific primary and specialty care clinics.
3. NYCHHC-North Brooklyn Health Network/Woodhull Medical & Mental Health Center's Patient Navigator Program, which includes nine bilingual navigators who are stationed at the front lobby information desks and at various clinics to greet non-English speaking patients and to provide them with information and assistance.

### Community Relations and Outreach

Community Relations and Outreach includes needs assessments of the local community; community-based services and programs such as health fairs, case management, public relations, and advocacy; campaigns targeted at meeting the health and psychosocial needs of local community populations; partnerships with community-based resources and leaders; and in-hospital training and education for staff and clinicians on community needs and values.

Organizational cultural competence requires a substantive understanding of the communities served and the ability to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the organization's service area. Responsive service delivery to a community requires a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are informed by the community's healthcare needs and based in the community, are more likely to be used by patients, and lead to more acceptable, responsive, efficient, and effective care.

Examples in this domain include:

1. Memorial Healthcare System's Hispanic Program is a community campaign that offers community-based services, fosters partnerships with community resources, and comprehensively markets itself to the local Latino community.
2. Harborview Medical Center in Seattle has established the Community House Calls/Caseworker Cultural Mediator Program, where caseworker cultural mediators provide a wide range of services, including: interpretation, cultural mediation, case management, advocacy, follow-up, coordination of patient care, health education, home visits, and assistance in accessing English as a Second Language and citizen classes.
3. UMDNJ's Latino community health center in Newark, New Jersey, addresses the needs of the city's growing Latino community, provides services to more than 5,000 patients annually, and acts as a vehicle for conducting research to more effectively serve the Latino community.



### ***CEO Focus Group***

*Findings from discussions on the leadership components required for developing and maintaining effective culturally and linguistically appropriate health care.*

A focus group was held during the NAPH Fall Conference in Washington, DC, in November 2002, with nine senior executives from NAPH member hospitals. The focus group examined the important elements of establishing an organizational vision for culturally and linguistically appropriate health care services. The senior executives identified leadership tools they employ for designing, implementing, and maintaining cultural competence practices at their very diverse organizations. The group also provided suggestions for additional information needed to promote cultural competence efforts in public hospitals and health systems including recommendations for the development of a tool kit for practitioners, support staff and administrators.

Participants shared examples of how cultural competence would be reflected in their organization's core mission at the daily practice level in the next five years. Three themes emerged from the comments. First, the central premise of culturally and linguistically appropriate health care services is that these practices are inextricably linked to quality of care and customer satisfaction. The focus group participants underscored the belief that all patients are to be treated with respect and as effectively as possible in order for culturally and linguistically appropriate health care services to be successful. Second, culturally and linguistically appropriate health care services should be outcome-focused and ultimately result in equal health outcomes for all in the community served by the hospital or health system.

Third, culturally competent practices must be central to the performance of staff at all levels of the organization. In order to realize the goal of a fully institutionalized program of culturally and linguistically appropriate services, these practices and policies should be fully embraced by all employees; all professional staff may be trained at the outset of their employment but all staff should also be provided with training focused explicitly on customer service; and the leadership of the hospital must be responsible for establishing the organization's commitment and enthusiasm. Senior leaders need to ensure that the training and education activities provided at their organizations go beyond superficially addressing the health care-related cultural needs of their patients.

The focus group participants identified the operational features of a culturally competent hospital and health system that should be instituted and reinforced by senior leaders:

- All patients are treated with respect as individuals and receive high quality services. Senior leaders should transmit a clear and unambiguous understanding of their institution's goals, policies and values regarding the provision of culturally competent care.

- ❑ Demographic information from the area served by the hospital or health system is continually reviewed so that the organization anticipates change in community needs. To the greatest extent possible, senior leaders should attempt to create a workforce that is representative of the patient populations served. In addition, senior leaders need to provide staff with current information and education focused on the specific health care needs of large patient groups within that organization's catchment area.
- ❑ The assessment process for patients includes information on cultural beliefs.
- ❑ Patient care is responsive to the patient's cultural and linguistic preferences and concerns. Senior managers need to make sure all staff are aware of the full capabilities of their facilities in serving LEP patients. They also must ensure the availability and high quality of their facility's interpreter services, signage and key documents.
- ❑ Providers actively seek patient input.

The results of the focus group informed the development of the guides used to identify “models that work” within NAPH hospitals and health systems. Two sets of flexible interview guides were developed for the case studies: a general guide used in the initial discussions with key staff at the institutions and a more targeted guide used with senior leaders in the institutions selected for the case studies.

### ***Toolkit***

*A prototype designed to assist providers in planning, implementing and sustaining a culturally competent health care delivery operation in the public hospital setting*

Included in this report is a prototype for a web-based toolkit to transmit lessons learned in the development of the case studies. The toolkit would be designed for providers to assist in planning, implementing, and sustaining a culturally competent health care delivery operation that reflects a genuine commitment to meeting the CLAS standards.

The proposed toolkit kit was designed with advice from senior executives at NAPH member hospitals and health systems regarding needed information and the most appropriate format was supplemented by research into current toolkits and formats. A discussion of culturally and linguistically appropriate services was held during a committee meeting of key CEOs from public hospitals and health systems at the 2003 NAPH annual conference that was instrumental in the design of the toolkit. Five (5) areas were identified as critical needs for research and training:

- (1) Identifying the core competencies that make up culturally competent practices
- (2) Developing performance metrics
- (3) Measuring performance through self-assessment tools and benchmarks
- (4) Identifying models of effective practices
- (5) Making the case for cultural competence practices internally (strategic planning, staff training and staff development) and externally, especially by addressing cultural competence as a business case

The following subject areas would be covered in the proposed toolkit:

- Areas of toolkit focus: Leadership, Language Services, Community Outreach, Planning & Monitoring, Customer Service, Infrastructure, Clinical Services
- Examples of toolkit content:
  - **Index/table of contents** will have an index for each section of the toolkit so that users can easily identify information they are looking for.
  - **Preface** will include: the purpose; scenarios of use; types of users; the goals; and the concrete strategies for achieving different aspects of an organization that provides culturally and linguistically appropriate care. The purpose of this toolkit, which differentiates it from other similar efforts, is to address the specific “how, what, when, and where” of integrating cultural competence into the management and operations of a health care facility.
  - **Demographic information** that will assist in creating a business case for integrating cultural competence into health care systems and in addressing the issue of health care disparities.
  - **Examples of leadership and programmatic strategies** derived from case studies.
  - **A quick reference guide to laws, regulations, and guidelines** that apply to equal access to health information and services for limited English proficient (LEP) and other vulnerable populations from sources such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee on Quality Assurance (NCQA), DHHS Office of Civil Rights (DHSS/OCR), and Centers for Medicare & Medicaid Services (CMS).
  - **Model program designs** that will include information that is customized for all levels of organization (executive leadership, program operations, and clinical services) in a health care facility. The tiered design of the toolkit is intended to provide resources and information appropriate to the interests and responsibilities of various senior staff.
  - **Model effective plans on language assistance for LEP individuals** will be included to reflect strategies for implementing accurate and effective communication between patients and staff - a most fundamental component of the health care encounter. In accordance with current DHHS/OCR guidance, model plans for implementing language assistance incorporated in the proposed toolkit will be a practical and experience-based “walk-through” for providers and will include: (1) Identifying LEP persons who need language assistance; (2) Language assistance measures; (3) Training staff; (4) Providing notice to LEP persons; and (5) Monitoring and updating the LEP plan.

- **Development and budgetary strategies** section will incorporate information on how to create an effective, long-term program. Start-up and maintenance costs will also be addressed for the benefit of executive leadership and program operations. The costs involved in developing and conducting culturally competent activities in health care organizations will be outlined as a tool for senior staff members to estimate budget concerns.
- **Sample policies & procedures** that will outline strategies for implementing culturally and linguistically appropriate policies. The policies will address the role of minorities as a consumer and as an employee.
- **Sample translated documents/marketing material**, particularly those vital documents reflected in the provisions of DHHS/OCR guidance and that promote and enhance meaningful access for LEP populations.
- **Case studies** of NAPH hospitals and health systems that describe promising and effective practices in culturally and linguistically appropriate health care.
- **Key NAPH meeting and forum summaries** that will present the leadership components needed to plan, develop and sustain an environment that reflects a belief that serving culturally and linguistically diverse communities is part of the core mission of the organization.
- **Organizational assessment tools:** In a responsive and accountable health care organization, the monitoring of performance, quality and financial indicators is essential in order to meet the needs of patients, staff and the communities served. Based on current research, we propose developing a data-based management assessment and monitoring system that provides senior leaders with a timely and meaningful overview of their organization's response to the needs of the diverse communities served. This is envisioned as a data-driven management tool that would facilitate organizational commitment and orientation to providing culturally and linguistically appropriate health care services.
- **Online discussion** section for executive management from several organizations to communicate with one another.
- **Database** of information on cultural competence relevant to public and voluntary hospitals and health systems, as well as web linkages to key resources. This section will also include a glossary and bibliography.
- Proposed toolkit format:
  - Web-based on NAPH homepage
  - Related marketing and instructional material (written and other visuals)
  - Possible CD-Rom version

## ***Recommendations to Strengthen Culturally and Linguistically Appropriate Services in Safety Net Institutions***

This project has provided excellent insight into the wide array of culturally and linguistically appropriate practices in NAPH hospitals and health systems. The extensive programs and services in this area illustrate the critical role safety net institutions play in providing quality health care that is responsive to the needs of their diverse patient populations. This report distills the most significant and applicable strategies from the variety of programs and approaches studied over the course of the project. Our findings have led to four major recommendations for further work in the area of culturally and linguistically appropriate practices.

The recommendations call for additional resources, technical assistance and coordination of services to both expand culturally and linguistically appropriate practices and to target them more specifically. Several of the recommendations center on the CEO, recognizing the essential role played by the leadership in safety net institutions in initiating and supporting culturally and linguistically appropriate practices. Although CEO leadership in this area has been significant, it is generally a solitary endeavor, with limited resources and technical assistance. Building and sustaining work in cultural competence depends upon resources and training aimed at the senior leadership.

All of the recommendations are based on our review of the programs, services and practices in many of our member institutions, the advice and analysis provided by some of our executive leaders and other key senior staff, our review of the literature on culturally and linguistically appropriate services, and our examination of sample toolkit designs.

The recommendations also address the constraints imposed by various mandates for services without regard to sufficient resources. Safety net hospitals and health systems are large, complex institutions with multiple, sometimes competing, priorities and needs. The great demand for culturally and linguistically appropriate services is one of many priorities. Efforts to meet this demand in this area may be hampered by insufficient resources and technical assistance.

### **Recommendation #1:**

**Public hospitals and health systems need support to develop data systems that will provide timely, accurate metrics to monitor performance in providing culturally and linguistically appropriate care.**

A number of key NAPH member CEOs suggested several critical areas for research and training for more effective management of culturally and linguistically appropriate practices:

- Identification of the core competencies that make up culturally competent practices
- Development of performance metrics
- Measurement of performance through self-assessment tools and benchmarks

In order for the senior staff in public hospitals and health systems to monitor performance in a timely and accurate manner, enhanced data systems are essential. The data needed to properly identify disparities in health care is not always readily available. Technical assistance and resources are greatly needed to identify key metrics in safety net institutions and to develop data systems to secure these metrics on a regular basis. In addition, we strongly support collaboration with national initiatives, such as the one being conducted by the Health Research and Education Trust (HRET), which are geared toward developing uniform data systems that facilitate strategies for eliminating health disparities.

Initial work in building relevant data systems should focus on assessing the state of existing data as it relates to culturally and linguistically appropriate services, including content, availability, and manageability of the data. Specific questions to be addressed in developing a useful data system include:

- What performance measures are needed to monitor cultural competence practices in an institution?
- How can performance data be collected and analyzed in an accessible and timely manner?
- What systems are in place to use data effectively to ensure the maximum impact of financial and human resources dedicated to culturally and linguistically appropriate services?

#### **Recommendation #2:**

**Technical assistance is needed to develop measures for evaluating the efficacy of strategies to serve culturally and linguistically diverse populations.**

The public hospitals and health systems surveyed for this report are to be commended on the extent and variety of the programs and practices they offer to diverse patient populations. Yet, much of this work is entrepreneurial without guidance or assistance. For example, some of the most experienced, sophisticated chief executive officers among our member hospitals indicated that assistance is needed to monitor the performance of culturally and linguistically appropriate practices and to demonstrate the effectiveness of these practices.

Our second recommendation calls for the development of a management performance assessment and monitoring system that provides senior leaders with a timely and meaningful overview of the organization's response to the needs of the diverse communities served. This is envisioned as a data-driven management strategy that would facilitate organizational commitment to providing culturally and linguistically appropriate health care services.

The development of key metrics would enable senior staff to address critical questions in the provision of culturally and linguistically appropriate health care such as:

- How does a senior leader ensure that management and organizational practices directed to ensure cultural competence are effective?
- What is the relationship between culturally competent practices and reducing health disparities or improving health outcomes for specific groups?
- What is the effect of culturally competent practices on improving patient safety and quality of care?

### **Recommendation #3:**

**In order to facilitate the dissemination of lessons learned, a practical administrative and programmatic toolkit should be developed in the area of culturally and linguistically appropriate services in hospitals and health systems that focuses on implementation strategies for senior leaders, program administrators, and clinicians.**

Our research into the various toolkits currently available in the area of culturally and linguistically appropriate services found that most of these are geared toward promoting awareness rather than implementation, especially at the senior management level. Consequently, our third recommendation calls for support for the development of a toolkit as a practical resource for effective implementation of culturally and linguistically appropriate services. This is an effort to advance the field by offering a practical, hands-on and system-oriented tool for dissemination of lessons learned during the research phase of this project.

The recommended toolkit would serve as a practical guide for administrators and providers in a website-based medium and would include the following:

- Identification of culturally competent clinical care
- Assessment of community needs and building of community relations
- Workforce, training and education programs
- Improvement in language access and interpreter services
- Strategies for financial and infrastructure supports for cultural competence initiatives;
- Key elements of effective leadership
- Organizational assessment tool (i.e., an “executive dashboard”) for monitoring and managing the performance of an organization serving culturally and linguistically diverse populations.

Model program designs in this proposed toolkit would include information that is customized for all levels (executive leadership, program operations, and clinical services) in a health care organization. The goal of a tiered tool kit design is to address the multi-faceted nature of serving diverse populations and to integrate cultural competence strategies throughout all sectors and levels of the organization. In addition, there will be clear marketing and budget strategies that will incorporate information on how to create an effective, long-term response to the cultural and linguistic needs of diverse communities, including start-up and maintenance costs for the benefit of executive leadership and program operations.

We would recommend a web-based handbook on the NAPH homepage containing the elements described in the section of this report entitled, *Proposed Toolkit Content and Development*.

#### **Recommendation #4:**

**More effective coordination is needed among the Office of Minority Health's unfunded standards and guidelines, the requirements of directives monitored by the DHHS Office of Civil Rights, and the current funding mechanisms administered by DHHS.**

Because the need is so great, much of the work among our member hospitals is in the area of interpreter services. As noted in the case study, Hennepin County Medical Center, for example, currently has 42 full-time interpreters and receives requests in more than 60 languages. However, the need for interpreter services produces a great burden on public hospitals because it is essentially an unfunded mandate. It is extremely costly to provide sufficient numbers of interpreters, to develop interpreter training and certification programs, to produce written materials that are translated appropriately, and to respond to demographic changes that affect the demand for interpreters. Public hospitals and health systems have developed interpreter services guided in part by the standards established by the DHHS through Office of Civil Rights and OMH.

Strategies for implementing culturally and linguistically appropriate care and for reducing health disparities cannot be successful if the providers serving diverse populations are underfunded. NAPH members are proud of their long history of providing high quality care to anyone regardless of their ability to pay, which has provided access to care for millions of low income patients, including untold numbers of patients from culturally and ethnically diverse backgrounds. Yet the burden of providing care without reimbursement takes its toll. Approximately 26 percent of the services provided by the average NAPH member are uncompensated, as compared to an industry average of 6 percent. At the same time, public sources of support for this care have been drying up. We urge DHHS to explicitly recognize the connection between limited funding and the ability of safety net providers to provide the kind of care that will enhance cultural competence and reduce disparities.



# **Case Studies**

**Boston Medical Center**  
One Boston Medical Center Place  
Boston MA 02118

*Executive Leadership Serving A Diverse Patient Population*

**Background**

Boston Medical Center (BMC) is a private, not-for-profit, 547-licensed bed, academic medical center located in Boston's South End. The hospital emphasizes community-based care, with a mission to provide consistently accessible health services to all in need. BMC, which is the primary teaching affiliate for Boston University's School of Medicine, is the largest safety net hospital in New England. *U.S. News and World Report* ranked BMC as one of the best hospitals in the nation. In 2003 BMC was recognized for excellence in six specialties: respiratory, rheumatology, geriatrics, neurology/ neurosurgery, cardiac care, and kidney disease. The most recent edition of *America's Top Doctors* lists fourteen physicians from the medical center. In order to advance the growth of their mission, BMC's philanthropic initiatives generated \$10.5 million in 2001 compared to \$500,000 three years ago.

BMC's mission statement reflects the goal of providing quality and accessible health services through an integrated delivery system regardless of status and ability to pay, in an ethically and financially responsible manner with particular emphasis on the needs of vulnerable populations.

BMC has an average of 850,000 patient visits each year, including 26,000 admissions. Over the past five years, inpatient volume has increased by 15.5 percent, and outpatient volume by 12 percent. BMC has a range of over 70 areas of medical specialties and subspecialties and is the largest Level I trauma center in New England; its emergency department had over 100,000 visits last year.

Last year the hospital provided approximately \$246 million in free care to uninsured populations, of which \$148 million was reimbursed by the Free Care Pool, a state-sponsored indigent care financing mechanism supported by providers and payers. Numerous outreach programs can be found at the hospital including skin cancer screenings, osteoporosis screenings, eye exams, smoking cessation counseling and flu shots. Youth outreach workers are trained for involvement in schools and health fairs, and cancer education and prevention seminars are offered in the community as well.

BMC serves primarily the city of Boston in Suffolk County, which has a population of 689,807. Just over half (52 percent) of the city is White, 20.6 percent are African American, 15.6 percent are Latino, and 6.9 percent are Asian. The primary languages spoken by BMC patients requesting interpreter services are Spanish, Haitian Creole, Cape Verdian, Somali, Chinese, Bosnian, Albanian, Vietnamese, Russian, Portuguese, Kurdish, and Arabic.

Patients that seek care at BMC are primarily low income. More than half of the patients have an annual income of \$17,000 or less. Approximately half of BMC patients are either uninsured or are covered by Mass Health, the Massachusetts Medicaid program. The patient population is very diverse; 30 percent of the medical center's patients do not speak English and need an interpreter when accessing care.

## Overview

When asked how she approaches the job of leading an urban academic medical center dedicated to serving a diverse community in today's environment of shrinking public resources, Mrs. Elaine Ullian, CEO of BMC, responded: *"We take everything down to pretty simple levels...our whole approach here is to create an environment where we feel so good about it and so confident about it...that we would get our care here and our families would get our care here. That, to me, is the gold standard."*

Dr. John Chessare, BMC's Chief Medical Officer and Associate Dean for Clinical Affairs at Boston University School of Medicine, reinforced Mrs. Ullian's statement: *"This (leadership) team benefits from the fact that the legacy of Boston City Hospital was very rich...historically, our predecessor organization really celebrated the fact that it was serving a diverse group of people with needs. So that at the time of the merger, there was already a rich history of diverse patients with a fairly well-developed interpreter services department...with people delighting in the fact that they were serving many, many different types of people, and with the budgetary recognition that it had to happen."*

In an interview on May 5, 2003, Mrs. Ullian outlined her executive strategy for leading a public hospital renowned for providing culturally and linguistically appropriate health care services:

- Transform BMC into a "hospital of choice" by supporting caregivers in their sense of mission to provide health care within a strong social context;
- Articulate clear objectives and expectations with accountability and consequences for performing and performing the work appropriately;
- Create, and operate within, a flat organization (CEO also functions as the COO);
- Be highly accessible to staff, governing body, patients, and the community;
- Be very visible - practice "Management-by-Walking-Around";
- Reach out to community leaders to build a constituency base;
- Put great emphasis on staff development, especially on skills building for front-line supervisors and managers;
- Establish accountability to the governing body, especially in the area of diversity using a balanced scorecard to track and measure progress;
- Develop a collegial and effective working partnership with the academic program through a close working relationship with the leaders of the medical school.

## Leadership

### *Translating Principles into Program*

The following are examples of leadership principles articulated through operational strategies and programs. Mrs. Ullian promotes an environment conducive to providing quality care to a diverse population with the assistance of the consulting services of Cochran Hadden Royston Associates. This consulting firm has over thirty years experience in cultural diversity, human resources development and administration, organizational development, culture change and crisis management. The principal consultant, Gwen Cochran Hadden works closely with executive management, senior leaders and staff to develop and implement various aspects of a comprehensive approach to serving a diverse community.

### *Accountability – The Balanced Scorecard*

Elaine Ullian: “*We have metrics on diversity...we have a diversity goal (but) how can I evaluate it...we did this because year after year we kept talking about diversity, and nothing was changing. And I said to the leadership team, the only way I can make this change is if I make myself publicly culpable. And guess what? They’re with me...at the board meeting I’m going to report our numbers. I am going to put a flashlight on this so I can’t say, oh, we didn’t get to it this year.*”

BMC continues to use a balanced scorecard for articulating and subsequently tracking progress in six areas of organizational performance (quality of care, patient satisfaction, public health access, financial viability, employee safety, and diversity). Each year the organization becomes more familiar with this approach and more skilled in using the scorecard to advance and enhance the enterprise. The scorecard is distributed each month electronically to all managers and physicians and is posted on BMC’s Intranet Web page. It is also reviewed at leadership meetings, departmental meetings, Medical Management Council and employee town meetings.

### *Performance Metrics at BMC*

The following are excerpts of reports that present performance metrics for FY 2002 and FY2003 in the balanced scorecard format. The most significant revision for the FY 2002 balanced scorecard is the addition of the major category of *Diversity* - creating and supporting a more diverse management, technical and professional workforce at BMC.

## *Sample Report: FY 2002 Balanced Scorecard Metrics*

*The performance goals for FY 2002 build on the goals and accomplishments of the past year. As previously discussed, we are adding a new category to the Balanced Scorecard and launching a multi-year initiative to enrich the diversity of the BMC workforce.*

*Diversity: Develop and support employment opportunities to increase diversity at middle and senior levels of the organization.*

*Year 1: Increase overall departmental minority representation in all management, professional and technical positions.*

*The diversity goal reflects a major multi-year organizational commitment to develop a workforce that more closely reflects the ethnic and racial composition of our patient population.”*

*The following are excerpts of Elaine Ullian’s Annual Report to the Board, October 2002:*

*“The Balanced Scorecard for FY 2002 highlighted the following goals and associated metrics for BMC:*

*Diversity: Develop and support employment opportunities to increase diversity at middle and senior levels of the organization.*

*Year 1: Increase overall departmental minority representation in all management, professional and technical positions.*

*Results: Target achieved. The diversity goal reflects a major multi-year organizational commitment. The objectives of the first year work plan, which included introduction of summer internships and full time administrative residency positions at BMC, were achieved. Though metrics were not established, of the four “director level” positions filled at BMC, three were filled by minorities.*

*FY 2003 Balanced scorecard metrics:*

*The proposed performance goals for FY 2003 reflect our commitment to improve on the work that we have done, and to enhance the overall performance of the medical center. In reviewing the FY 2003 metrics, the categories remain the same, however some defining measurements have changed. For example, we added a second Quality of Care metric for FY 2003. It speaks to the serious problem in hospitals nationwide linked to hospital-acquired infections. Another modification of FY 2003 metrics is the Access goal. Our access goals for FY 2003 speak to the community need for enhanced cancer screening/ early interventions: we also focus on improved access to BMC through reductions in ED diversions. In all instances, we believe that the goals and suggested scores will keep the organization focused on what is most important in serving our patients, improving our processes, and creating a healthier community.*

*Diversity: Implement year 2 work plan, which continues recruitment efforts and adds retention strategies to increase minority representation in all management, professional and technical positions.*

## Interpreter Services

Elaine Ullian: *“The sense of mission here is palpable. People come to work here not just to be excellent care givers, but to be excellent human beings...the social context in that is evident from our chairman of surgery to the person who works at the information desk...I think you need to send a message out in the community that we’re... respectful of different cultures and respectful of different races, and that we believe in treating everybody with dignity here, which we do. So I think one of the hallmarks of interpreter services is that we talk a lot about respect, dignity, and compassion.”*

BMC has proven to be a leader in many aspects of health care, especially in meeting the needs of a diverse population. With cultural competence becoming a focus for the nation’s health care delivery system, BMC has taken steps to create an environment where all patients can receive the appropriate care deserved regardless of their race, ethnicity or language spoken. One of the important strategies used by BMC in promoting this value is an effective Interpreter Services Department that provides on-site translation in 17 languages, and is available 24 hours a day for patients of Limited English Proficiency (LEP). By mid-2003, BMC had answered nearly 101,928 requests for interpreter services.

Before the merger that created BMC, Boston City Hospital became the first hospital in the nation to offer interpreter services. Today, members of this department attend scheduled appointments, walk-ins and respond to emergencies. Interpreters also routinely visit every unit to ensure clear communication between patients, staff, and providers.

BMC has one of the largest and busiest interpreter services departments in New England. The medical center employs 35 full-time employees in the interpreter services department and covered 122,000 interpreter services requests in 2002. BMC averages over 200 scheduled interpreter services requests per day, in addition to walk-in and emergency room patients. Utilizing a customized web-based scheduling system for interpreter requests, staff is able to reduce wait-times for interpreters who routinely perform rounds, seeking LEP patients on the floors and covering the emergency room as needed. The Interpreter Services Department also maintains a registry of contracted and per-diem interpreters, as well as three different language line providers. It also dedicates one special telephone line with dual handsets and 10 pre-programmed direct interpreter lines for the parents of newborns, including those in critical care. In 2002 BMC began utilizing video interpreting for sign language and 30 additional spoken languages in Adult ER, Urgent Care, Pediatric ER and Primary Care.

Since the passage of a Massachusetts law in 2000 requiring the provision of interpreter services in the emergency department, BMC has developed its own interpreter training program targeted to inpatient services and other departments. This training program is comprised of a 40-hour course co-administered and licensed by Harvard Pilgrim Health Care. In an effort to facilitate effective communication with the LEP patient population, several key documents (e.g., discharge instructions, surgical prep instructions, patient rights, and other key patient instructions) have been translated into Spanish, Portuguese and French. These documents are available to all providers on a hospital Intranet site and are downloadable and printable at kiosks throughout the medical center.

The FY2003 budget for Interpreter Services is \$2.2 million.

### **Staff Development and Training**

Elaine Ullian: *“We are spending a tremendous amount of energy trying to get our front line supervisors and managers the skill sets and competencies they need to be more effective...teaching people how to assess candidates, how to evaluate them, how to coach them, how to intervene, how to have a difficult conversation. All those things are really, really important.”*

Patricia Webb, BMC's Vice President for Human Resources, has pointed out that the organization is committed to supporting a climate where staff has confidence about their long-term future, both professionally and personally. Ms. Webb indicates, *“Nothing is more important to BMC's continuing success than our 'human' resources.”* BMC's division of Organizational Development and Training/Human Resources offers a wide range of programs and services to the BMC community, with more than 80 workshops ranging from *Working in Teams to Meeting the Emotional Needs of the Terminally Ill*. The discussion also provides customized programs based on individual business objectives and publishes a complete catalog of programs and services. These are designed with the needs of all staff in mind.

As part of an organizational commitment to staff training and development, during each fiscal year all management staff are required to participate in eight hours of training, two hours of which are specifically focused on cultural diversity training. Senior leadership has the vision to support staff development in the equally important areas of skill building and long-term behavioral/cultural change. In addition, the link between language barriers and customer service is a focus of a four-hour class given collaboratively by the Human Resources and Interpreter Services Department, for all those in front-line positions, including nurses and security personnel. In an effort to enhance patient access services (admissions/registration) throughout the hospital, a cross-functional team has been established to develop and deliver workshops and on-site interventions for managers and staff in these areas. The staff/patient dialogues integrated throughout the modules have been designed to address the unique and diverse needs of the BMC community (patients, families and staff).

It is the goal of BMC to support learning and career growth at every staff level throughout the organization, including developing the skills needed to move, for example, from a position in transport to a position in the labs or to assist managers in the initiation of performance improvement efforts. BMC's *Organizational Development and Training Catalog* is posted on the BMC's Intranet Web page. Registration services are also available on line.

The FY2003 budget for Organizational Development and Training is \$160,000.

## *Workforce Diversity*

When asked how one promotes an understanding of health care for a diverse population on the part of clinical, administrative, and support staff, Elaine Ullian responded: “...*First of all, we keep trying to hire people from many different cultures so that our employee workforce mirrors our patient population. I think we do a fairly decent job of that.*”

Asked about areas she viewed as needing improvement, Mrs. Ullian responded: “*Let’s start with our nurses. We don’t have enough minority nurses. We have struggled in getting African American and Latina or Latino RNs. That will take a big push...and that is a shared goal for two of my vice presidents this year. Second...and very visible and large...is I would like to see a lot more people of color in our director and manager roles.*”

This commitment to workforce diversity on the part of BMC is also expressed by the medical school, as Dr. Chessare points out: “*We have ...a Minority Affairs Office that oversees aiding clinical departments in providing clerkships for minority medical students from medical schools across the country, under the belief that if a talented minority medical student gets to know us better she will be more likely to put us high on her rank order list, and will be therefore more likely to come and join our residency training program.*”

BMC’s *Recruitment and Retention Plan to Enhance Workforce Diversity* is a three-year plan (FY 2002 to FY 2005) with the objective of increasing the recruitment and retention of minority employees at the management, professional and technical levels. The responsibility for implementation rests with the senior management group and workforce diversity coordinator. Detailed action steps include evaluation of current strategies and the maximizing of internal, external, and community recruitment resources.

The plan includes developing a BMC presence in local and national minority colleges, universities, and professional and community organizations and identifying minority organizations for college students at local colleges and universities to coordinate sponsored job fairs and career days. In addition, BMC’s organizational development & training department constructs a curriculum for managers who are required to take at least two hours of diversity training each year.

### **Community Relations & Outreach**

Elaine Ullian: “...*We are bringing in community leaders. Which community leaders? (They are) people who don’t know us, who philanthropically never supported us. And I call them my blind dates because they don’t know me and I don’t know them. We do one or two visits a week, if you can imagine. It’s incredibly time consuming, to build a constituency of people who normally don’t know who our patients are, and who may previously not even pick up the phone on our behalf, let alone write a check. It is community organizing at its most basic. And the beauty of that, is that I tour every single person. So I literally am walking through the hospital once or twice a week just because I’ve had somebody with me to show the place off...We (also) hold cultural diversity forums, which are really powerful...you hear people saying, ‘This is what it’s like to be from Haiti’...We have a lot of, ‘Now I get it’, types of things. That, I think is very good.*”



The entire BMC leadership team participates in quarterly cultural diversity forums around issues that impact the health and health care of the community. These forums are organized and facilitated by the diversity consulting group retained by BMC and are held for the major population groups seen at BMC, including Hispanic/Latino, Haitian, Cape Verdian, Somali, Vietnamese, Portuguese, Arabic, Chinese, Polish, Albanian, Russian, and Kurdish. All of the forums are videotaped and made available for all staff to use in the human resources department.

In exploring new ways to serve the community, BMC has expanded many groundbreaking programs. The Grow Clinic, offering comprehensive care for children suffering from malnutrition, is one such program. In 2003, the medical center opened its Preventive Food Pantry, a resource for patients and their families who otherwise would not get enough to eat. The goals of the Food Pantry are to emphasize the link between nutrition and overall health and to train primary care providers in identifying and preventing malnutrition before it becomes severe. Mrs. Ullian points out that these *"efforts reflect the spirit of outreach that characterizes this hospital. Exceptional care without exception."*

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**Community Health Network of San Francisco/San Francisco General Hospital Medical Center**

1001 Potrero Avenue  
San Francisco, CA 94110

*Health Care Services Planned and Administered for a Diverse Population*

**Background**

San Francisco General Hospital (SFGH) is the centerpiece of San Francisco's Community Health Network, a division of the city's Department of Public Health. The focus of the Community Health Network is on "...the broad health needs of all San Franciscans, with a special emphasis and commitment to serving the City's most vulnerable, diverse populations." SFGH is a public hospital serving the county of San Francisco and its diverse population of approximately 750,000 residents. The hospital has been at the same location in the Mission neighborhood of San Francisco since 1872, and its research and teaching affiliation with the University of California, San Francisco, dates back over 125 years.

In 2001 SFGH had over 700,000 outpatient visits. Of those visits, 35 percent were from patients covered by Medicaid and 44 percent from uninsured patients. Over half of inpatient discharges were covered by Medicaid in 2001. The patient population at SFGH during the same period was approximately 29 percent Latino; 24 percent White; 21 percent African American; 20 percent Asian/Pacific Islanders; and 6 percent other groups. The principal languages spoken by non-English speaking patients at SFGH are Spanish (43 percent), Cantonese (38 percent), Russian (5 percent), Vietnamese (5 percent), and Mandarin (3 percent).

SFGH is licensed for 686 staffed beds and offers an array of health care services in the areas of general medicine, surgery, critical care, specialty care, women and children care, AIDS care, and psychiatry. Outpatient services are provided through more than 100 primary care, specialty care and subspecialty care clinics. The hospital is the largest acute and rehabilitation facility for psychiatric patients in the San Francisco area and offers the only psychiatric emergency services in the city.

SFGH is the designated Level I trauma center for the city of San Francisco and the counties of the West Bay. In this capacity, SFGH is the lead hospital in the city for bioterrorism training and treatment. The hospital is also the leading health care facility in the city for earthquake responsiveness, coordinating training exercises with the police and fire departments and the emergency medical services, and holding community sessions for city residents about earthquake preparedness.

**Overview**

SFGH has a long tradition of employing a diverse staff to serve the city's population. The diversity of the staff is considered an important part of the hospital's mission to serve its patients well. Patients come to the hospital precisely because there are many staff from various cultures. This feature of the hospital's hiring practices was visible in a tour of the hospital and was underscored by senior nursing staff in the emergency, oncology, psychiatric, and labor and

delivery units. For example, the head oncology nurse noted that because people deal with death and dying in different ways, *“it helps to have staff here from different cultures.”*

San Francisco General Hospital is notable for its cultural competence practices in several respects. The hospital is the primary health care facility for the Department of Public Health. The Department’s commitment to cultural competence practices is evident in policies and procedures that govern the operation of the hospital and provide support for cultural competence initiatives. The interpreter services department at SFGH, headed by Gloria Garcia Orme, RN, MS, provides an extensive range of interpreter assistance to patients at the hospital. The inpatient focus units that address the needs of specific population groups distinguish psychiatric services at SFGH. To illustrate the work of the focus units, this case study will describe the Asian focus unit headed by Dr. Francis Lu.

## **Leadership**

The San Francisco Health Commission, which sets policy and governs the Department of Public Health, adopted a cultural competency policy that is based on the CLAS standards. This policy is included in all contract language from the Department of Public Health and is part of the Department’s planning, workforce development, and monitoring and evaluation practices. To implement this policy the Department of Public Health established a cultural competence committee that is composed of 15 managers from the departments of public health. Daily integration of cultural competence services is managed by this committee.

The Department of Public Health developed a comprehensive model for culturally competent care that provides a framework for all aspects of the hospital’s work in this area and for the department’s community health programs. This model has four guiding principles:

- Cultural competence is an essential ingredient in the design, administration and delivery of effective services.
- Consumer, family, and community participation in the planning and delivery of services is essential for achieving cultural competence.
- An effective culturally competent system of care requires linkages and partnerships with other departments, community agencies and resources.
- A culturally competent system of care promotes wellness and recovery and focuses on strength-based models of care.

## **Interpreter Services**

San Francisco General Hospital was one of the founding corporate members of the California Healthcare Interpreters Association whose mission is to develop and promote the healthcare interpretation profession. The Association advocates for cultural and linguistically appropriate services and provides education and training to health care professionals.

The interpreter staff at SFGH provides assistance in over 20 languages. Fifteen FTE interpreters are available seven days a week from 8 a.m. to 12 midnight, and an additional 100 on-call interpreters are available in up to 35 languages. A language line providing 100 languages is also used when additional interpreters are needed. Staff calls the dispatcher in interpreter services,

and when the need for an interpreter is identified, a dispatcher triages the requests, prioritized by their urgency. Interpreters are available by pager after regular hours.

Interpreters are trained through *Bridging the Gap*, a 40-hour course. Interpreters are also recruited from City College of San Francisco, which offers a year-long training course and a Health Care Interpreter Certificate at completion. Students are required to take several academic courses in basic medical terminology, human physiology, and interpreting in health care settings, and to complete fieldwork. Students in the course train at SFGH as well as other Bay Area hospitals. There are plans to offer a course at the hospital to train bilingual staff as interpreters. The course will be offered one evening per week with a language lab on Saturday. An interpreter certificate will be offered at the end of the training to all successful candidates.

Interpreter assistance is tracked through a database that records every interpreter assistance call and the amount of time an interpreter spends with the patient. Tracking interpreter contacts helps the interpreter services department examine usage and anticipate trends. Patient satisfaction surveys include questions about interpreter services that assess, among other factors, whether or not the patient understood the interpretation. Interpreters are trained at SFGH to let the provider know when the interaction between patient and provider is not working.

SFGH has recently introduced the use of video conferencing in a pilot test with 150 patients. One of the goals of the video conferencing is to expand the pool of interpreters by sharing interpreters among San Francisco area hospitals. Many clinic exam rooms at SFGH have been wired to support the video camera. The video conferencing is used when the provider is ready to call for an interpreter. This arrangement reduces the waiting time for the interpreter and expands the number and type of interpreters available. The video conferencing has been tested on Chinese, Vietnamese, and Spanish patients. Interpretation around diabetic treatment has been a particular focus. The technology worked well in the pilot test with an immediate and clear connection between the provider, patient and the interpreter.

Nurses who have used the conferencing have found it to be very helpful, especially in terms of its ability to protect patient privacy. A chief concern in the pilot study is to determine patient satisfaction with this arrangement. Gene O'Connell, Executive Administrator, and other members of the senior leadership at SFGH are very supportive of video conferencing; unfortunately, likely budget cuts will make widespread adoption of the technology difficult.

### **Clinical Services – The Asian Focus Unit**

For more than 20 years the psychiatry department at San Francisco General Hospital has operated inpatient focus units to serve the mental health needs of particular population groups in the city. Francis Lu, M.D., who is the director of the Cultural Competence and Diversity Program in the Department of Psychiatry at SFGH and Professor of Clinical Psychiatry at the University of California San Francisco, coordinates the inpatient psychiatric focus program. In fiscal year 2002-2003, there were 3,025 admissions to the inpatient program.

The focus units at SFGH modeled themselves conceptually on pre-existing outpatient focus programs in the San Francisco Community Mental Health Services. The SFGH program provides specialized, culturally competent care in four acute psychiatry units that serve Asian

Americans, Latinos, African Americans, women, lesbian/gay/bisexual/transgender individuals, and persons with HIV/AIDS. Three-quarters of the work in the focus groups is on substance abuse and the concomitant health and mental health problems and disorders.

In 1980 the Asian focus unit was officially established as the first inpatient focus unit by Dr. Lu who was then chief of the inpatient psychiatric unit. Dr. Lu established the Asian Focus unit to link inpatient to outpatient services for Asian Americans who at the time made up 21 percent of the population in San Francisco. Evelyn Lee, Ed.D., served as Program Director of the Asian Focus Unit early in the unit's history from 1982-1988. Dr. Lee co-managed the unit with Dr. Lu. She was an inspiring leader for program development, workforce recruitment and retention, training and community outreach.

Although the hospital's leadership was very supportive of the Asian focus unit, it took ten years to reach a full complement of staff. Recruitment of Asian physicians in psychiatry was difficult because Asian medical students go into psychiatry at half the rate of other medical students. Part of the recruitment effort involved bringing in students to see the work of the focus program. The addition of a Cantonese-speaking psychologist, a very difficult position to fill, rounded out the staff. Today, the languages spoken on the Asian focus unit include Mandarin, Cantonese, Hakka, Taiwanese, Toishan, Chiu-Chow, Shanghainese, Fukienese ( all dialects of Chinese); Tagalog, Ilocano (both spoken in the Philippines); Vietnamese; Malay; Hindi, Punjabi, Urdu, Tamil, Malayalam and Russian.

Dr. Lu was instrumental in recruiting and mentoring key staff in the unit. In setting up the unit the intent was to have staff with backgrounds and perspectives similar to the patient population. A multidisciplinary approach was used to form the staff, which includes cultural social workers, nursing staff, and an occupational therapist. In addition to recruiting a culturally diverse staff, the Asian focus unit provides training to UCSF psychiatric residents, medical students, psychology fellows, and nursing students as well as social work and occupational therapy students from other schools.

The focus unit programs at SFGH have received two national awards: the American Psychiatric Association Certificate of Significant Achievement in 1987 and the American College of Psychiatrists Creativity in Psychiatric Education Award in 1999.

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**Denver Health**  
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*Leadership in Reducing and Eliminating Health Disparities*

**Background**

Denver Health is Colorado's primary safety net institution. The health system includes a 349-bed hospital housing the only Level 1 trauma center in the area, a 12-clinic network of family community health centers, a 13-clinic network of school-based health centers, the 911-medical response system for the city and county of Denver, and the Denver Public Health Department. Denver Health provides preventive, acute and chronic health care for over a quarter of all Denver residents, or 160,000 individuals. One of every three children in Denver is cared for by Denver Health physicians.

Denver Health averages over 16,000 inpatient discharges and 745,000 outpatient visits per year. Forty percent of the patients seeking inpatient care at Denver Health are covered by Medicaid and another 39 percent are uninsured. Of those seeking ambulatory care services, 58 percent are uninsured and almost a quarter are covered by Medicaid.

The county of Denver has a population of approximately 550,000 people. Over 40 percent of the population can be classified as minority, with African Americans comprising 11 percent of the population and Latinos comprising 32 percent. Asians comprise almost 3 percent of the population.

**Overview**

The important role of leadership is evident in all of the case study sites included in this report because the various programs and practices highlighted here are the result of the commitment and drive of each institution's leadership. This case study illustrates the crucial part that leadership plays through a focus on Denver Health. Denver Health has always treated a very diverse patient population that includes patients of Hispanic, Russian, Vietnamese, and Arabic origin or descent. The issue of health care disparities is of such great importance to the health system's leadership that a number of initiatives have been adopted to study the issue and assure that any disparities are eliminated.

The study of ethnic disparities began with an assessment to examine possible racial and ethnic disparities for patients seeking care at Denver Health. Researchers studied outcomes for patients receiving care for diabetes and hypertension, as well as for women being screened for breast and cervical cancer. Researchers studied the data across levels of poverty, race and ethnicity, and found no apparent disparities in the provision of recommended interventions and screenings.

Denver Health strives to have no ethnic disparities in health outcomes and has incorporated this objective into the organization's strategic plan. The health system's leadership has made cultural competence a priority that is linked to all of the organization's activities.



Denver Health has recently embarked on a series of activities ranging from capital investments in information systems, new construction and renovations to the redesign of the ambulatory care visit. These are all activities that improve health care quality, patient safety and patient satisfaction. At the same time, because Denver Health's patient base is so diverse, these activities are directly linked to the improvement of care provided to racial and ethnic minorities. When the health system embarked on these various initiatives, the objective was to support the strategic goal of eliminating health care disparities. The commitment to eliminating disparities is also evident in other discrete activities throughout the health system, such as those described below.

## **Leadership**

### *Operationalizing Cultural Competence*

Denver Health has developed a five-year plan for implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. In fall 2002, three teams were established and assigned with developing recommendations and implementation plans for the various CLAS standards. The first team is the infrastructure solution team, which was charged with developing a plan for the provision of culturally and linguistically appropriate services. Various objectives for this team include updating policies and procedures for accessing linguistic assistance, developing processes for patients to file grievances to address unfair cultural or linguistic treatment, and developing certification requirements and competency levels for determining staff's functional capacity for performing interpreter services. The Patient documentation translation team was charged with providing translated patient materials (including educational materials, appointment information, financial forms, and surveys) in accordance with OCR guidance requirements. Finally, the right of entry team was charged with assessing the accuracy of signage throughout the health system, ensuring that patients have the ability to identify their primary language at all primary points of entry, and providing innovative alternative solutions for disseminating information to patients, customers and the community.

The various teams are making progress in meeting their objectives and expect to fully execute the implementation plan in the next five years.

### *Participation in HRSA's Health Disparities Collaboratives*

Denver Health has been a participant in the Health Disparities Collaboratives sponsored by the Health Resources and Services Administration's (HRSA's) Bureau of Primary Health Care (BPHC). The goal of the collaboratives is to generate and document improved outcomes for underserved populations. This is achieved through the development and implementation of comprehensive models of care for various diseases. In the late 1990s, Denver Health participated in the BPHC's original disease collaboratives for diabetes, depression and asthma.

Denver Health has built upon the work started through the various collaboratives. For example, Denver Health has done a great deal with a patient registry developed as part of the diabetes collaborative. The registry contains information on approximately 700 patients in a clinic in which 46 percent of the patients are African American and nearly 40 percent are Latino. The registry has been used to track lab results for patients receiving diabetes care, to invite patients to

diabetes education programs, and to identify patients who fail to seek follow-up care, and registries are currently being developed for the health system's other internal medicine clinics. The diabetes education program developed through the HRSA collaborative has been expanded, and English and Spanish diabetes education classes are now held at all three of the health system's internal medicine clinics on a weekly basis.

Since the 1990s Denver Health has participated in other collaboratives to improve outcomes for underserved patients with cardiovascular disease, HIV, and substance abuse problems. The health system has also used the models developed through the cooperatives to improve immunization rates and the provision of prenatal care.

### *Participation in AHRQ Studies*

As one of nine Integrated Delivery System Research Network awardees, Denver Health participated in the Agency for Healthcare Research and Quality's (AHRQ) study on the impact of race and ethnicity on the access, use and outcomes of care. Specifically, Denver Health (which has had a fully integrated information system, IDS, since 1997, in conjunction with the Research Triangle Institute and the Weill Medical College of Cornell, collaborated to assess the capacity of integrated delivery systems to contribute to research in this area. The collaborative examined the extent to which data from integrated delivery systems could be used to conduct studies on the impact of race and ethnicity on the access, use and outcomes of health care services.

The second AHRQ study studied racial and ethnic disparities in access and use of care related to diabetes. Study results suggested that racial and ethnic minorities within the Denver Health system did not demonstrate lower rates of diabetic procedures or lower quality of care compared to Whites. The study identified several programs that may help to mitigate disparities, including interpretation services, community outreach services, patient education, and staff training.

## **Community Relations and Outreach**

### *Participation in Community Voices*

Denver Health is also one of thirteen grantees participating in the W.K. Kellogg Foundation's Community Voices program. The goals of the Community Voices initiative include increasing access to health services for the vulnerable (with a focus on primary care and prevention), strengthening safety nets in communities by fostering closer integration among providers, delivering care in more cost-effective ways, and developing best practice models that other communities can adapt to their unique circumstances.

One of the areas that Denver Health is concentrating on through its participation in Community Voices is community outreach. The community outreach program is designed to demonstrate that culturally sensitive community outreach to underserved populations improves the enrollment of eligible individuals into health plans and empowers communities to assume greater responsibility for health.

As part of the community outreach activities, community health advisors at Denver Health have held a series of focus groups with Latino and African American males of different ages to learn

why these groups often fail to seek medical care. The focus group discussions revealed that there is wide distrust of the health care system among African American males of all ages, largely driven by the unethical way in which the Tuskegee Study was carried out. Among Latino men, discussions revealed that the more newly arrived immigrants tended to postpone seeking medical care due to fears about immigration status or lack of understanding about the U.S. medical system. Reasons cited by second-generation Latino men (who tended to be the younger participants) were more often influenced by their experiences of discrimination and generally mirrored the perceptions of African American men.

Because so much of the literature on health care disparities focuses on African American and Latino men, learning about the reasons why these groups tend to avoid or postpone seeking medical care can be invaluable in developing strategies to eliminate disparities in health outcomes for these groups.

While the Community Voices program was created as a five-year initiative that will soon come to an end, Denver Health will continue with its various community outreach and community involvement activities beyond the formal conclusion of the project.

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**Harborview Medical Center**  
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*Quality Care for a Culturally and Linguistically Diverse Community*

**Background**

Harborview Medical Center (HMC) is located within King County, in downtown Seattle, Washington. Founded over 125 years ago as the second hospital in the Northwest Territory, HMC has a long history of playing a leadership role in times of disaster, and serving as the safety net for patients and other hospitals throughout the region. Today, HMC is a 351-bed facility that has become a comprehensive, internationally recognized center for patient care, teaching, and research for trauma, burns, neurosciences, orthopedics, and HIV/STD. As the Pacific Northwest's only Level I Adult and Pediatric trauma center, HMC also serves patients from across a four-state region that includes Washington, Idaho, Montana, and Alaska.

According to its mission statement, HMC's primary mission is "to provide and teach exemplary patient care, and to provide health care for those patients King County is obligated to serve." King County has over 1.7 million inhabitants. According to the 2000 U.S. Census, approximately 75 percent of the county's population is White, 11 percent is Asian, 6 percent is Latino, 5 percent is African American, and about 1 percent is either American Indian/Alaska Native or Native Hawaiian/Other Pacific Islander (0.5 percent). Over 18 percent of King County residents speak a language other than English at home. Illustrative of this diversity, during 2001 HMC handled over 103,000 requests for interpreter services in more than 60 different languages. The majority of these requests were for Spanish (23 percent) followed by Somali (22 percent), Vietnamese (15 percent), Cambodian (7 percent), Amharic (5 percent), Cantonese (4 percent), and Tigrinya (4 percent). All other languages combined make up the remaining 20 percent of interpreter services requests that year.

In 2001, HMC discharged 16,800 inpatients and provided 330,995 outpatient visits (including ED visits) at its facilities. The majority of these services were provided to low-income and/or uninsured patients. More specifically, Medicaid covered 40 percent of the 16,800 inpatient discharges and 10 percent were uninsured. Of the almost 331,000 outpatient visits, 30 percent of patients were covered by Medicaid and 26 percent were uninsured.

**Overview**

HMC serves a broad spectrum of patients to maintain a balanced clinical program and fiscal viability. However, Harborview's mission statement explicitly states that the "non-English-speaking poor" and "indigents without third-party coverage" are two of the priority groups to be cared for with the resources available at HMC. To accomplish these goals, HMC has in place numerous examples of its organizational commitment to providing high-quality and culturally competent health care to King County's most vulnerable populations, regardless of their ability to pay. Outstanding among them are: (1) the Community House Calls/Caseworker Cultural

Mediator Program, (2) the EthnoMed web-based clinical tool, and (3) the International Medicine Clinic.

## **Community Relations and Outreach**

### *Community House Calls/Caseworker Cultural Mediator Program - Expanding and Supplementing Interpreter Services*

The Community House Calls/Caseworker Cultural Mediator Program was started in January 1994, with the goal of decreasing linguistic and cultural barriers to health care for limited-English speaking populations receiving care at HMC. Community House Calls was initially a demonstration program funded by the Opening Doors Initiative of the Robert Wood Johnson and Henry J. Kaiser Family Foundations. The program received matching funds from the Washington State Department of Health and Human Services, additional funding from Harborview Medical Center, and training assistance from the Pac Med Cross Cultural Health Care Program in Seattle. Since then, the program has moved beyond the demonstration phase, gained hospital-wide acceptance, and found a long-term home at Harborview through administratively merging with the medical center's Interpreter Services Department.

The program has been shown to be highly effective in facilitating dialogue between providers and their diverse patient populations. The program expands the role of medical interpreters into the more comprehensive role of Caseworker Cultural Mediators (CCMs) in recognition of the inherent difficulties that arise when health care providers attempt to offer quality health care to ethnically diverse populations within a confined timeframe and without adequate knowledge of a patient's language, cultural background, or current living situation.

CCMs provide a wide range of services, including: interpretation, cultural mediation, case management, advocacy, follow-up, coordination of patient care, health education, home visits, and assistance in accessing English as a Second Language (ESL) and citizenship classes. They give didactic presentations at the hospital and in the community and work with the community to identify and remove barriers to health care. The CCMs also play a role in providing health care providers with cultural information and information about cultural health care practices and beliefs. In fulfilling that role, they have become an established part of provider training and patient care at HMC.

The Community House Calls program expands and supplements Harborview's interpreter services by integrating ethnographic and medical anthropological principles into healthcare provision and medical education goals. Its specific programmatic goals are to:

- Create a common fund of knowledge between medical and ethnic cultures;
- Decrease language barriers to care;
- Change institutional practices that decrease patient satisfaction for limited-English speaking families;
- Improve cross-cultural healthcare education for providers and trainees; and
- Enhance efficient utilization of resources by "high risk/high need" families.

These goals are achieved through the CCMs' provision of: health care and education services (particularly continuity of medical interpreter services); case management for families with complex social or medical needs; home visits; training for families (e.g., enabling them to make their own clinic appointments and obtain pharmacy refills); community health education; and training for healthcare providers in the practice of intercultural medicine.

CCMs follow a family or patient over a period of time, becoming aware of their needs, problems and strengths. This case management approach allows CCMs to provide cultural interpretation and mediation and enables them to advocate for appropriate treatment based on a more thorough understanding of the patient. Conversely, the CCMs can better communicate cultural facts and social/familial histories to the healthcare provider, offering the provider a way to gain valuable insights that can positively impact patient care. Problems such as poor housing, lack of childcare or support for new parents, depression, isolation and mental health problems can be identified and addressed more easily through use of the CCM approach. Although CCM cannot solve all the problems a family or patient may have to contend with, the avenues for communication are vastly broadened and cultural gaps more easily bridged when a CCM is involved in patient care.

### *Focus Populations*

The combination of cultural mediation with case management enables CCMs to be extremely effective at addressing the specific healthcare needs of several of Harborview's largest vulnerable patient populations. The CCMs at HMC currently provide services to patients from the following ethnic groups: Cambodian, Somali, the Tigrigna speaking peoples from Eritrea and Ethiopia, the Amharic speaking peoples from Ethiopia, Spanish and Vietnamese.

The Community Housecalls Program at Harborview includes seven caseworker cultural mediators, a nurse supervisor, community advisors, a program administrator, a medical director, and other health and social services professionals from both within and outside of Harborview. The CCMs are bilingual and bicultural persons familiar enough with the biomedical and American cultures to (1) act confidently within the healthcare system and (2) be known, trusted, and have influence with the institution's providers and clinic teams. At the same time, the CCMs' bicultural, bilingual backgrounds enable them to serve as a trusted contact and advocate for non-English speaking families from the same ethnic background.

### *Program Implementation*

The Community House Calls program has prescribed steps for recruiting and selecting CCMs, training CCMs, and developing the administrative and logistical supports necessary for the program's success. As a result of the program's successful implementation, CCMs can be found in primary care clinics and inpatient clinics throughout HMC, as well as in some specialty clinics, such as mental health and the burn unit.

### *Integrating Community Input and Resources to Improve Care*

Community involvement in the recruitment and selection of CCMs is important to ensure that the individual ethnic communities feel a sense of ownership in the program and to incorporate the

insights of community leaders who can guide the selection team toward candidates who are truly capable of representing their community. Community support of the applicant is an important component of the selection process because that support influences the candidate's ability to work successfully in the role of a CCM.

In the early stages of Community House Calls, monolingual community advisors from each ethnic group were identified and sought out as cultural informants and program assistants. They were selected on the basis of their knowledge of traditional forms of healing, their role in decision-making within the community, their strong presence in the community, and the fact that they retained much of their former culture.

Community advisors also play an important role in the area of cross cultural health research. They often serve as members of focus groups that help inform the design of cross cultural health research projects. Professionals who are bilingual and bicultural also provide important feedback and guidance through their involvement as members of the community advisory board.

Ethnic community associations are involved in Community House Calls by representing refugee and other immigrants in their local area, participating in recruitment of CCMs and community advisors, and providing a meeting place for community health education and outreach activities. CCM program staff and faculty invest as much time as possible in developing and nurturing relationships with ethnic community associations because the support of community leaders will have a great impact on how well the CCMs will be integrated into the fabric of community life. The CCM will be able to work most effectively if the larger community actively supports him or her. With the help and support of the community, activities such as youth associations, daycare, women's groups, ESL, and other forms of support become established in the neighborhood. These supports often also become important components of the case management approach utilized by the CCM team.

Case managed families have a number of needs related to housing, nutrition, education, mental health, and other social services. Those who are refugees often live with post-traumatic stress disorder, fear, and depression. Other immigrants feel isolated, lacking access to their traditional social structures and the cultural traditions that provided support for their families in their home country. As CCMs become more familiar with the case-managed families, they often become involved in negotiating with social service agencies, interpreting for the families in those settings, and educating the families about how to access appropriate resources.

### *Program Evaluation and Improving Outcomes*

Program evaluation results indicate the promise of the Community House Calls program. In one evaluation, patient satisfaction in mothers who were enrolled in CCM care coordination was compared to levels of satisfaction seen in mothers who were not similarly enrolled. Cambodian mothers were surveyed about their own health care and that of their children, before and after one year of program operations. Cambodian mothers who received care-coordination through the Community House Calls program were clearly able to identify the CCM as a helpful person who worked in the hospital and who could easily be contacted. Mothers in the control group were not as able to identify a hospital staff person who was a consistent contact for help with

health issues. No other differences were identified between the attitudes of the two groups of mothers towards their health care experiences at baseline or after one year of program operations.

A second program evaluation examined the levels of knowledge acquired by pediatrics residents about the various ethnic groups treated at HMC and the management of interpreted clinical visits. Pediatrics residents were divided into one group that was exposed to the Community House Calls program and worked with CCMs and a control group that was not exposed to the program. Through interviews conducted both before the program started and after one year of operation, evaluators found that both groups of residents improved in their specific knowledge about the ethnic groups they served during their rotations. However, residents who were exposed to the program and worked with the CCMs had significantly higher scores on their knowledge of the native languages spoken by their patients' ethnic groups, patients' countries of origin, and patients' asylum issues. They were also significantly more likely to be aware of the pros and cons of various interpretation styles, to understand that some foreign words and concepts cannot be accurately translated into English, and to be cognizant of the probable influences of the age and gender of an interpreter on the quality of a particular patient visit.

## **Infrastructure**

### *EthnoMed*

EthnoMed is a web-based clinical tool containing medical, cultural, and community information about non-English speaking immigrant groups living in the Seattle area. Its purpose is to make previously difficult to access information about culture, language, health, illness, and community resources directly accessible to health care providers when they need it. In Harborview's ambulatory clinics, each examination room has a computer terminal. Consequently, just before or while treating, for example, a Cambodian patient with asthma, a provider can use a computer terminal to access EthnoMed and read how the concept of asthma is translated in Cambodian, and what common cultural and interpretive issues surround asthma management in the Cambodian community. EthnoMed also enables a practitioner to download written and recorded patient education materials (often in the patient's native language) to give to the patient both during and/or at the end of the visit.

EthnoMed content includes cultural profiles on HMC's most prevalent non-English speaking patient populations; culture-specific sections on health and illness; information about ethnic community resources; downloadable and translated patient education materials; and an interactive user dialogue site, including digital audio recordings pertaining to health behaviors and/or dealing with particular conditions. Files are identical in the way they are organized, so a clinician can quickly navigate all other files once he or she is familiar with the uniform file structure.

Ethnic community profiles that have been developed and reviewed by members of Harborview's local ethnic organizations include: Amharic, Arab, Cambodian, Chinese, Eritrean, Ethiopian, Hispanic, Lao, Mexican, Mien, Oromo, Samoan, Somali, South Asian (Indian subcontinent), Tigrinyan, Ukrainian, and Vietnamese. Other ethnic groups will be included as materials are



written. Harborview welcomes comments and suggestions from members of ethnic groups from around the world. As providers learn from their patients about traditional treatments, cultural perspectives or resources, Harborview urges them to share this information with the staff responsible for EthnoMed.

EthnoMed is a joint project of the University of Washington Health Sciences Library and the Harborview Medical Center's Community House Calls Program. EthnoMed team members work with other staff at the University of Washington and members of the community who serve as EthnoMed's writers, community contacts and reviewers. Potential contributors are first asked to contact the EthnoMed development team to let them know that he or she is interested in contributing to EthnoMed. If the potential contribution's subject matter is appropriate, contributors then collect information on the topic they wish to write about. Contributions that will utilize ethnographic data are referred to EthnoMed's guidelines for collecting ethnographic data. Templates for other forms of documents (i.e., cultural profiles and "typical" EthnoMed contributions) are also provided to foster EthnoMed's uniform document structure, which is offered as a guide, not a required format.

Upon completion, contributors are asked to submit their documents in electronic format to the EthnoMed librarian. EthnoMed editors then assist contributors, as needed, to adapt documents and link them with appropriate community readers. Community readers subsequently review all submissions for accuracy, prior to inclusion and posting on EthnoMed.

EthnoMed is intended to be a community voice in the clinic, so user feedback is essential. HMC staff believe that cultures are dynamic. As groups acculturate, traditional concepts become modified. Thus, as an interactive electronic medium, EthnoMed is particularly well suited to capturing and expressing changes in cultural needs and nuances.

As immigrant groups acculturate and communities react to these changes, EthnoMed reflects this pattern of change. Ethnic organizations are urged to tell Harborview about ongoing activities and resources in order for that information to be added to their local resource information. HMC staff also solicit periodic reviews and feedback from community leaders about changing health concepts in their communities. As noted above, community members also review all contributions to EthnoMed prior to that contribution being published and placed on the website.

## **Leadership and Interpreter Services**

### *International Medicine Clinic*

Leaders at Harborview Medical Center (HMC) have developed a unique International Medicine Clinic, located in the middle of its five ground-floor ambulatory clinics, dedicated to providing primary care for limited-English speaking patients. Staffed by certified interpreters and a multidisciplinary, bicultural and bilingual health care team dedicated to addressing the special needs of non-English speaking patients, the clinic handles approximately 12,000 visits annually and is located adjacent to the hospital's main entrance. The small pharmacy within the clinic's confines is located there specifically to assist limited English speaking patients requiring medications. In addition, the interpreter services department, Community House Calls program

office, and Patient Education Center are all located in very close proximity to the clinic. International medicine clinic services include: physical exams, preventive health care, illness treatment, interpreter services, birth control, pregnancy tests, immunizations, on-site pharmacy, hearing and vision screening, health education, and mental health counseling. Since many clinic patients practice non-Western healing traditions, acupuncture, massage and herbal medicine are also available, and HMC providers collaborate with such community healers when necessary. The clinic also collaborates with other community health agencies on important public health projects.

The International medicine clinic provides adult refugees and immigrants (ages 16 and older) with high quality primary care services. Limited-English speaking adults who have immigrated from Asian and African countries are provided care through a staff of medical assistants/interpreters who speak the languages most commonly encountered within that clinic. These languages include: Amharic, Cambodian, Cantonese, Chao Jo, Mandarin Mien, Hmong, Laotian, Mien, Oromo, Somali, Tigrinya, and Vietnamese. Outside interpreters are routinely used for additional interpretation support.

The Interpreter Services Department (ISD) at Harborview provides qualified medical interpreters for both limited-English-speaking and hearing impaired patients. HMC interpreters are certified or screened by the Washington State Department of Social and Health Services (DSHS), and complete professional training for medical interpreters through the Cross Cultural Health Care Program in Seattle. The ISD coordinates the services of both staff interpreters and business associates who, combined, cover more than 50 languages. The ISD can also readily access other community interpreter agencies to increase their pool of languages significantly. In 2001, the ISD's annual budget, which included the Community House Calls program, was over \$3.2 million.

Operationally, interpreter requests originate in HMC's medical clinics. The ISD schedules the majority of the interpreter requests they receive in advance. Requests can be made from 24 hours to several months before a patient's appointment. However, same-day scheduling is available and utilized for walk-ins, emergency room and urgent care appointments. Staff interpreters frequently conduct rounds in the International Medicine Clinic as well providing translation services as needed. When necessary, the ISD also utilizes Pacific Interpreters for telephonic interpretations. After hours and weekend requests for interpreters can be made by HMC staff by dialing the hospital's operator.

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**Hennepin County Medical Center**  
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*Communicating with a Culturally and Linguistically Diverse Community*

**Background**

Hennepin County Medical Center, located in Minneapolis, Minnesota, is a public teaching hospital whose mission is to provide outstanding health care services in an environment that promotes excellence in education and research. The medical center has 416 staffed beds and averages over 21,000 discharges and 440,000 outpatient visits per year. Almost half of the patients seeking inpatient care at the medical center are covered by Medicaid, and another 5 percent are uninsured. Of those patients seeking ambulatory care at the medical center, approximately 44 percent are covered by Medicaid and 14 percent are uninsured.

The majority of Hennepin County's one million inhabitants are White. Nearly 9 percent of the county's inhabitants are African American, 4 percent are Latino, and 5 percent are Asian. The medical center serves a very diverse patient base, including patients from the Hispanic, Somali, Southeast Asian (including Cambodian, Vietnamese, Lao, Hmong), Russian, and Bosnian communities. The two primary languages spoken by Hennepin County Medical Center's patient population are English (74 percent) and Spanish (16 percent). Asian languages account for 4 percent of the languages spoken, and an additional 6 percent of the population is classified by the hospital as speaking some "other" language.

**Overview**

The Hennepin County Medical Center's commitment to cultural competence is made evident through its Language and Interpreter Services Department. This department is distinguished by its size and the scope of the services it provides, the creativity of its interpreter scheduling system, and the rigor of its staff training and certification programs.

At the institutional level Hennepin County Medical Center is also taking steps to formalize its diversity initiatives and to incorporate specific cultural competence activities into its strategic plan. The chief operating officer has supported the development of a cultural competence assessment team. The team is conducting an institutional audit to lay the groundwork for the diversity program. Funding has been specifically allocated for this purpose.

**Interpreter Services**

*Size and Scope*

Hennepin County Medical Center has an extensive language and interpreter services department with over sixty interpreters—a combination of full-time and part-time employees as well as interpreters contracted from local agencies. The medical center employs 42 full-time interpreters who respond to communication needs in more than 60 languages, the most prevalent of which

are Spanish (68 percent) and Somali (17 percent). In 1995 the interpreter services department logged 33,000 interpreter contacts. By 2001 this figure had grown more than 300 percent to 141,000 interpreter contacts.

When an interpreter is not available in person at the medical center, interpreter services uses additional resources. For Spanish and Somali, the two most commonly requested languages, the Interpreter Services staffs a hospital-based over-the-phone interpretation service with two full-time Spanish interpreters and one full-time Somali interpreter. For 10 requested languages for which there is no in-house interpreter, Interpreter Services maintains 10 voice mailboxes. When an individual leaves a message in the voice mailbox of a particular language, it activates an interpreter's pager who then returns the patient's call. These hospital-based interpreter services are supplemented, when necessary, by the AT&T Language Line, a 24 hours a day, 7 days a week interpretation service that provides over-the-phone interpretation in more than 150 languages.

To complement Hennepin County Medical Center's interpreter services, there are also 60-70 educational brochures and informational sheets that have been translated into 6-10 different languages on the medical center's Intranet. A staff member working with a diabetic patient from El Salvador, for example, can go to any computer in the hospital and print out a brochure in Spanish that explains diabetes care.

### *Creative Scheduling*

Hennepin County Medical Center's interpreter services employ a variety of strategies to schedule their interpreters. Interpreter services also works with the employees who schedule appointments in the hospital's clinics to help them better schedule the patients who require interpretation.

Interpreters can be scheduled at the time a patient's appointment is scheduled. They can also be requested and available for walk-in patients who come to the medical center without an appointment. For advanced scheduling, interpreter services' supervisors periodically meet with the hospital's clinics to review the scheduling practices that are most efficient for the interpreters. Interpreter services encourages the clinics themselves to be aware of the language needs of their patients and to try to schedule patients sequentially who require interpretation in the same language. If a clinic schedules two patients who require a Spanish interpreter at the same time, this either requires that two Spanish interpreters come to the clinic at the same time or that one of the patients wait. Conversely, if one of these patients is scheduled in the morning and one is scheduled in the afternoon, an interpreter will have to travel to that clinic twice. If these patients are scheduled back-to-back however, and a single interpreter needs to make only one trip and can provide interpretation services to both patients without having to make either of them wait. This is an example of a scheduling practice that effectively uses an interpreter's time.

To facilitate the use of interpreters, Hennepin County Medical Center has established several language specific primary care and specialty care clinics including pediatric, obstetric/gynecology and diabetes clinics. These clinics, targeted at Russian, Spanish and Somali patients, respectively, are staffed by clinicians and employees who are native speakers of that clinic's primary language. The clinics are also staffed by medical interpreters who provide

further interpretation support in the clinic's primary language. The Russian clinic, for example, is a primary and specialty care clinic staffed with Russian-speaking doctors and nurses, as well as a Russian-speaking medical interpreter. Bringing many Russian-speaking patients together at one clinic increases the number of patients for which a single Russian interpreter can interpret.

Interpreter services has also implemented a one-stop shopping system at its interpreter-staffed medical clinic. At this clinic interpreter services tries to ensure that a physical therapist and a mental health professional are on site as well as the clinic's primary care practitioners. With the physical therapist and mental health professional also available in the medical clinic, an individual who requires interpretive services can stay with one interpreter in the same location for a prolonged period of time, and use that interpreter for the primary care/specialty doctor-patient exchange as well as for some of the additional services that he or she may require. This saves the patient time, helps maximize the interpreter's usage, and is less confusing for the patient who can stay in the same place and receive multiple services.

### *Staff Certification and Training*

While the Hennepin County Medical Center employs many bilingual staff, including practitioners in language-based clinics whose primary language is that of the clinic, these staff members are not formally used as interpreters and are not subject to the same training or standards as the professional medical interpreters. Professional interpreters at the medical center are currently tested on their written and oral skills. They are also tested on their knowledge of medical terminology. Interpreter services is in the process of creating a curriculum for interpreters that will include the standards for medical interpreting that are being developed at the county level.

To help familiarize the medical center's clinical and administrative staff with the use of medical interpreters, Interpreter services is leading an institution-wide campaign to educate staff about working with interpreters. As part of this campaign there are sessions termed "Lunch and Learns" for clinicians on subjects related to the use of interpreters, and an annual training included as part of resident trainings. There are also monthly trainings as part of staff nurse orientation on how to use interpreters in a medical training.

## **Leadership**

### *Institutionalizing Diversity*

When the current COO at Hennepin County Medical Center took over the role in the fall of 2001, she began to focus more closely on the issue of diversity within its workforce and patient population. Although the hospital offered diversity education to practitioners, the COO recognized that in order to effectively institutionalize diversity initiatives, work related to achieving culturally competent practices must be incorporated into the organization's overall strategic vision. To design a diversity program, the COO designated a coordinator who agreed to spearhead the development of this program with the understanding that institution-wide diversity initiatives could only be successful with the support and recognition of the organization's leadership.

### *Cultural Competence Assessment Team*

To begin work on the diversity program, the coordinator completed literature searches on the issue of cultural competence. She also interviewed staff on whether or not they felt the organization was meeting the needs of its diverse workforce. She focused on positive employees who had made a place for themselves in the organization. She then assembled an advisory group of individuals from different ethnic backgrounds and disciplines to evaluate the organization from top to bottom. This cultural competence assessment team includes representatives from the clinical areas, as well as from the management and the unions. The assessment team is responsible for determining whether the organization is meeting the needs of its employees and its patients, and for evaluating whether the medical center's current policies and procedures are sensitive to its culturally and ethnically diverse workforce and patient base. The goal of the assessment team is to identify gaps and to focus on ways to address such shortcomings. The workplan for this initiative was approved in May 2002 by the Operations Council, the medical center's decision-making body.

### *Institutional Audit*

The cultural competence assessment team is currently performing an institutional audit. The audit consists of interviews with representatives from all levels of the staff and with a representative sample of the racial and ethnic groups from the medical center's employee base. The audit began with interviews of the leadership team and the various departmental chiefs. This leadership assessment has been completed, and the cultural competence assessment team is in the process of developing its recommendations. Results from the audit will include an analysis of what cultural competence should look like when the medical center achieves it, a description of the current state, a gap analysis, and specific recommendations. Recommendations are expected to include a mix of immediate steps that can be taken as well as suggested additional assessments and measurements. Recommendations will be presented to the Operations Council in summer 2003.

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**Memorial Healthcare System**  
3501 Johnson Street  
Hollywood FL 33021

*Leadership Responding to the Health Care Needs of a Diverse Community*

**Background**

Memorial Healthcare System (MHS) is located in Broward County, Florida, in the southeastern part of the state, and primarily serves residents from the South Broward district. According to hospital representatives, its mission is to “provide quality, cost-effective, customer-focused healthcare services to its patients regardless of their ability to pay.” With 1,017 staffed beds across three hospitals, the system averages over 53,000 discharges and almost 639,000 outpatient visits per year.

Broward County has over 1.6 million inhabitants. Nearly 20 percent of the county’s residents are African American, 17 percent are Hispanic, and 2 percent are Asian. Almost a quarter of the population in this area speak a primary language at home other than English including 16 percent who speak Spanish or Spanish Creole, 3.5 percent who speak French Creole, 2 percent who speak French (including Patois and Cajun), and another 1 percent who speak Portuguese or Portuguese Creole.

**Overview**

Memorial Healthcare System’s commitment to providing culturally competent health care is exemplified by its Hispanic Program, which includes an extensive campaign targeted at the local Hispanic community. The program was first launched out of Memorial Hospital Pembroke. The program began with a needs assessment, and highlights several aspects of community outreach including community-based PR, community-based services, and partnerships with local Spanish-speaking physicians. The Hispanic Program is supported by several different departments within MHS.

Under the direction of its leadership, MHS has also developed and included in its strategic plan the 7 Pillars of Excellence. The 7 Pillars of Excellence are an employee code of conduct that emphasizes such institutional values as: quality, customer satisfaction (patients, employees, physicians, patients’ families), people (employees), and community. The healthcare system has incorporated the 7 Pillars into administrative structures like job descriptions, meeting formats, new employee training, and employee performance reviews. In order to benchmark levels of customer satisfaction at its hospitals, MHS also works with Press Ganey, a national patient satisfaction surveying agency. To better serve Medicaid recipients, MHS has also partnered with the North Broward Hospital District and the Jackson Health System to create the South Florida Community Care Network, a provider service network that serves Miami-Dade and Broward Counties.

## **Community Relations and Outreach - The Hispanic Program**

### *Infrastructure*

MHS's commitment to providing care that is responsive to the needs of the local community is evident in its extensive outreach to the local Hispanic community. Community outreach at MHS is organized by the community relations department and implemented by the community benefits department. A health fair, for instance, is organized by the community relations department, but staffed and run in the community by the community benefits employees. Both the community relations and community benefits departments fall under MHS's strategic planning and marketing department.

### *Community Needs Assessment*

In the late 90s, recognizing the need to serve the growing Hispanic population in the South Broward district, Memorial Healthcare System leased a facility in a largely Hispanic area. Called Pembroke Hospital, this newest addition to MHS was a run-down facility saddled with \$22 million of debt. MHS's CEO and Pembroke Hospital's chief administrator set about trying to identify the needs of the surrounding communities and to create measures to enhance the new facility.

Under the vision of these two leaders, MHS's strategic planning and marketing department conducted a needs assessment of Pembroke's target population. Central to the needs assessment was an analysis of the 1980 and 1990 censuses and census projections. To help them identify health, educational and economic needs within the community, the strategic planning and marketing department analyzed information on community issues, news, and events that they collected from local English and Hispanic newspapers, television news and radio shows.

### *A Community-Based PR Campaign*

Soon after the strategic planning and marketing department finished the community needs assessment for Memorial Hospital Pembroke, MHS launched its Hispanic Program. The Hispanic Program was designed to help meet the health and sociocultural needs of South Broward district's Hispanic community. As part of the Hispanic Program, the strategic planning and marketing department created a community-based marketing, recruiting, and public relations campaign targeted at Hispanic residents of the South Broward district. Strategic planning also developed an in-house educational campaign to teach Pembroke Hospital staff and clinicians about the community needs that it was able to identify from the needs assessment.

When the director of Hispanic Services developed the PR program, she created commercials, educational brochures, advertisements, and literature with the local Hispanic community in mind. She used pictures of hospital employees and other community members in her brochures and in the posters that she distributed to local doctors' offices. She asked Pembroke Hospital doctors to appear on local cable channels to talk about health issues as well as the services that the hospital provided. She convinced volunteers, former patients, nurses, and friends to be in the commercials that MHS ran on a popular Spanish television program. She organized a radio show

and invited Pembroke Hospital's doctors to discuss diseases prevalent in the Hispanic community. She advertised the hospital's services in several community tabloids, smaller local Spanish language newspapers and magazines, and submitted healthcare-related testimonials and pictures that featured community members. Her position within MHS also allowed the director of Hispanic Services to disseminate information about Pembroke Hospital and its services to community organizations on whose boards she sat.

### *Community Services and Partnerships*

As part of its Hispanic Program, MHS conducts health fairs in Spanish, offers free screenings at community events, and distributes its materials at these events in Spanish. MHS also administers free screenings at Hispanic Unity of Florida, an agency in the South Broward district that provides services to immigrants.

Through Pembroke Hospital's community needs assessment, Memorial Healthcare System was able to identify Spanish-English bilingual physicians in the community. MHS has partnered with these bilingual doctors, and through a physician referral service refers its Spanish speaking patients to these bilingual doctors. Partnering with local bilingual physicians has been helpful at MHS's health centers, many of which are in need of Spanish-speaking clinicians. The health centers contract out with the bilingual community-based doctors to offer primary care services in Spanish to their patients. The system has also opened up a primary care community health center with bilingual practitioners near Hispanic Unity of Florida.

## **Leadership**

### *Customer Satisfaction*

The executive leadership at Memorial Healthcare System has made customer satisfaction a priority, including it as one of MHS's 7 Pillars of Excellence, the employee code of conduct. In order to provide health services that satisfy the varying needs of its patients, MHS's leadership has emphasized that the organization be sensitive to the religious and cultural values of its patients, as well as meet the language needs of its non-English speaking patients.

In 2000 the head administrator of Memorial Hospital Pembroke decided that customer satisfaction should be the hospital's main goal. The hospital, newly acquired by Memorial Healthcare System, was run-down, in debt, and had not yet established a relationship with the community. Patient satisfaction was low. To help benchmark progress at the facility, the head administrator solicited help from Press Ganey, a national patient satisfaction surveying organization. Using measurement criteria determined by Press Ganey, Memorial Hospital Pembroke began to survey each inpatient about his or her stay at the facility. The surveys were sent back to Press Ganey for evaluation and analysis.

At the time they began working with Press Ganey, the hospital barely ranked at the 30<sup>th</sup> percentile for customer satisfaction in comparison to other hospitals of its size. Under the leadership of the head administrator however, the hospital became more proactive in identifying the community's needs and developing relationships with community organizations and

individuals. Community-oriented programs like the Hispanic Program, which provided community-based services in Spanish to the local Hispanic community, were launched. Over the next two years, Pembroke Hospital rose to the 99<sup>th</sup> percentile in customer satisfaction.

Following the success of Pembroke Hospital, MHS's leadership set the goal that the system's three hospitals rank in the top 5% nationally for their size in customer satisfaction. Memorial Hospital West began working with Press Ganey to document customer satisfaction at that facility, and has been able to increase customer satisfaction to within the top 5th percentile as well. MHS recently reached the goal of having its three hospitals rank in the top 5 percent nationally for their size in customer satisfaction. The organization has changed its goal, and, continuing to utilize Press Ganey's measurements of customer satisfaction, is working towards having its three hospitals rank within the national 5<sup>th</sup> percentile in customer satisfaction for all hospitals, not just other hospitals of their size.

### *Building Culturally Competent Care into the Infrastructure*

MHS has taken measures to build its commitment to providing culturally competent care into its infrastructure and administration including into staff performance evaluations and employee training. MHS leadership has also asked that job descriptions be redefined and meetings be structured to incorporate the 7 Pillars of Excellence, MHS's code of conduct.

Memorial Academy is an institution at MHS that focuses on staff training and education. Memorial Academy organizes and runs staff trainings like the three-day new employee orientation. Throughout this orientation, Memorial Academy teaches new employees about the system's priorities, goals and values. Academy staff trains new employees on MHS's definition of culture, which takes into consideration an individual's religious beliefs, ethnic values and personal convictions. The Academy emphasizes that providing culturally competent care does not just refer to interpretation services for an individual whose first language is not English. As part of the new employee orientation, Academy staff also introduce new employees to the ways in which the system tries to provide care that is culturally competent, familiarizing them with resources like the Special Needs Coordinator, the Language Pool—a computerized database that keeps track of the languages that multi-lingual staff speak as well as their hours and location of work, and the 7 Pillars of Excellence.

MHS also tries to measure and monitor an employee's sensitivity to areas related to cultural competence through annual performance reviews. These evaluations include questions that test an employee's knowledge of MHS's basic policies and procedures around such areas as interpreter services. For instance, an employee might be asked to answer the question: "What do you do if someone comes up to you and doesn't speak your language?" As part of this performance review, employees are also ranked on the 7 Pillars of Excellence that relate to their particular job. In concert with the Press Ganey survey instruments that are widely used by Memorial Healthcare System to measure patient satisfaction, evaluative ranks for employee performance are scored one through five.

### *South Florida Community Care Network*

In 1997 Florida passed legislation authorizing the Florida Agency for Health Care Administration (ACHA) to establish four provider service networks to serve Medicaid recipients. The AHCA defines a provider service network as “an organized health system operated by health care providers offering integrated systems of care to Medicaid recipients.” The intent of this legislative initiative was to develop integrated delivery systems to serve Medicaid recipients in Florida as an additional health care option for Florida residents who are eligible for Medicaid.

In 1998 MHS, along with North Broward Hospital District and the Public Health Trust of Miami Dade County (Jackson Memorial Hospital), submitted a joint proposal to AHCA to serve Miami-Dade and Broward Counties. These three entities represent large Florida public hospitals that have traditionally served the Medicaid population. The proposal was submitted under a legally incorporated entity, the South Florida Community Care Network. The proposal was accepted and the first PSN recipients enrolled on March 1, 2000.

Since that time the PSN has achieved significant results, including: development of four disease management programs; improved utilization of medical resources through use of contracted providers and care management collaboration; improved efficiency in the medical management of the PSN population; improved enrollee retention, reduction of preventable voluntary disenrollments through a strong enrollee services department, and monitoring of complaints and resolution strategies and timeliness; improved quality and disease management outcomes and high level of enrollee satisfaction with the care they received and with the administrative processes and procedures associated with their care. Support functions like customized enrollee orientation, provider education, PSN data management and reporting, and centralized program administration that includes quality and disease management initiatives and outcome measurements have been created with consideration of area specific needs. South Florida’s varied ethnic make-up has also played a key role in determining program design and educational materials.

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## **NYCHHC-North Brooklyn Health Network/ Woodhull Medical & Mental Health Center**

760 Broadway  
Brooklyn, NY 11206

### *Improving Customer Service for a Diverse Population*

#### **Background**

The North Brooklyn Health Network (NBHN) is the only municipal health care provider in North Brooklyn, New York, and plays a critical role, in partnership with the community, in identifying and addressing the health care needs of the neighborhoods of Williamsburg, Bushwick, Greenpoint, Fort Greene and Bedford-Stuyvesant. The Network is one of the seven vertically integrated health care networks of the New York City Health and Hospitals Corporation (NYCHHC), the nation's largest public hospital system. The Network's delivery system includes primary, specialty and acute care services with an emphasis on disease prevention and health promotion. Its mission is *"to provide the highest quality of health care to every patient with dignity, cultural sensitivity and compassion, regardless of ability to pay;"* it has a vision *"to be patient centered,"* and it promotes the values of *"CARES - Compassion, Accountability, Respect, Excellence and Safety."*

The Network's sixteen sites include Woodhull Medical and Mental Health Center, a 401 bed acute care facility; seven child health clinics that offer traditional public health and pediatric primary care services; the Cumberland Diagnostic and Treatment Center; four community-based health centers; and three school-based health centers/programs. Woodhull provides inpatient medical, surgical and behavioral health services, emergency care in three separate areas (adult, pediatric and psychiatric) and a wide range of primary and specialty services at over 50 ambulatory care clinics.

Annually the Network provides nearly 493,000 clinic visits, almost a third of which are primary care visits. In addition, Woodhull had 79,000 emergency room visits and over 18,500 discharges in 2002. Psychiatry is a major clinical service. Of the 401 beds in service, 171 or 43 percent are allocated for mental health services including alcohol and drug detoxification. Behavioral health is a major service area on the outpatient side as well. During fiscal year 2002 approximately 18 percent of outpatient visits at Woodhull and 32 percent at Cumberland Diagnostic and Treatment Center were for mental health and/or chemical dependency services.

Woodhull operates three free-standing residency training programs in internal medicine, pediatrics, and general practice dentistry and oral and maxillofacial surgery. The Network has a staff of over 3,000 FTE employees and an annual budget of \$288 million that comes from revenues, tax levy funds and grants. Over 260 full-time physicians and allied health professionals are available through the Network as the result of an affiliation agreement with the Woodhull Medical Group. All network physicians are board certified or board eligible.

North Brooklyn encompasses the primary and secondary service areas of the North Brooklyn Health Network. According to 2000 census data there are approximately 743,000 persons residing in the primary and secondary neighborhoods served by the network. The catchment

area includes some of the poorest neighborhoods with an estimated per capita income of \$8,512, almost one half that of the borough of Brooklyn (\$16,144).

According to the 2000 census, the residents of the Network's primary service area are 43 percent African American, 20 percent White, 3 percent Asian, and 34 percent members of other racial or ethnic groups. More than half (56 percent) of the primary service area residents identify themselves as Hispanic or Latino of any race. The patient population mirrors the diversity of the communities served. A comparison of the two largest facilities in the Network, Woodhull and Cumberland, indicates a very different racial composition: at Woodhull, 53 percent of patients are Latino and 37 percent are African American, while at Cumberland, 72 percent are African American and 24 percent are Latino. Although projections indicate a decline in the service area population since the 1990 census, new immigrants have been arriving in the area at a slightly higher rate than the rest of Brooklyn, originating primarily from the Dominican Republic, Poland, Guyana, Jamaica, Haiti and Trinidad and Tobago. In addition, there is a significant and growing Hassidic community in the service area of the Network. Nearly half (46 percent) of Network patients have limited English proficiency.

## **Overview**

The communities of North Brooklyn face serious problems in terms of health care access. Woodhull Hospital is located at the crossroads of three contiguous primary medical care health professional shortage areas (Bushwick, Williamsburg, and Bedford-Stuyvesant). The shortage of primary care providers combined with the social problems that plague low-income, high poverty communities have led to serious health status consequences for the residents. As Dr. Edward Fishkin, Woodhull's medical director, cites, most of the patients served by the Network live with this "urban health penalty" that handicaps the well-being of communities. Under his leadership, NBHN's patient-focused plan for care articulates the fundamental expectations he and his colleagues have of providers to meet the treatment, educational, cultural background and communication needs of patients and families in a respectful fashion.

According to the latest New York City health department vital statistics report for 2000, death rates (per 100,000 population) in two of the primary service areas (Bushwick and Fort Greene) are higher (in some cases, twofold) than New York City averages for HIV, chronic liver disease, diabetes, suicide, and drug abuse. Fort Greene has a neonatal mortality rate for teenage mothers that is one and a half times higher than the city average and an infant mortality rate for teenage mothers that is over three times higher. Bushwick and Fort Greene have one of the highest rates of adolescent pregnancy in the city.

Finally, asthma has had a devastating impact on the communities served by the Network and is the number one reason for hospitalization and emergency room visits by children at Woodhull. The rate of asthma in North Brooklyn is three times the national average and the number one cause of absences from school.

The critical health needs of the community coupled with the rich diversity of cultural, ethnic, racial and language backgrounds present not just a challenge but an opportunity for Woodhull to develop and implement model programs of care for diverse and LEP populations. Lynda Curtis,

NBHN senior vice president, cites patient safety and effective patient communication within a context of strong customer service focus as being central to providing quality health care in the Network. Asked how she and her leadership team would manage potential curtailments because of funding shortfalls, she indicated that programs tailored to provide quality care for a racially, ethnically and culturally diverse community are so important to the organization that they will not be options for cutbacks.

NBHN staff is committed to developing an organizational culture driven by accountability, continuous improvement and safety. They have adapted existing organizational structures to make them leaner and more efficient and to redesign processes to improve access for patients. Improving the physical plant to create a customer friendly environment and to support patient care processes remains a continuous goal. Further, in response to strategic indicators, the NBHN asthma revisit rate was consistently lower than the NYCHHC corporate average and the rate of enrollments in smoking cessation was higher.

### **Interpreter Services / Community Outreach - Improving Customer Service**

#### *Cultural and Linguistic Access to Services*

The Cultural and Linguistic Access to Services (CLAS) program provides a centrally coordinated interpreter service that includes four full-time, on-site staff who are proficient in Spanish, French or Polish in addition to bilingual staff working throughout the facility. Pre-screened for language interpretation skills by the New York University Center for Immigrant Studies, the interpreters are available by beeper. They also provide translation of written documents, including patient education material. Woodhull has devised a number of mechanisms designed to meet the language assistance needs of its LEP patients, whether oral assistance (interpretation) or written assistance (translation) is required. These measures are designed to ensure that all LEP patients have meaningful access to the care they need, and are overseen by Woodhull's language assistance coordinator.

All Woodhull patients are advised of their right to free language assistance services, either through posted notices placed strategically in various hospital locations or orally in their encounters with hospital staff. An LEP patient's primary language will initially be determined by staff using language identification cards, "I Speak" cards, or with the aid of telephonic interpretation services.

Once the LEP patient's language is known, staff may use one of the following methods to ensure effective communication is achieved:

- Bilingual clinical staff fluent in the LEP patient's language who have been assessed as capable of communicating medical information directly with the LEP patient;
- Where such a bilingual staff person is not available, the language assistance coordinator will be contacted and will, dependent upon availability, provide an interpreter for the LEP patient drawn from the hospital's language bank;



- Should such resources prove unavailable within a reasonable time, staff will use the telephone interpretation service, CyraCom, to communicate with the LEP patient. (Over 100 CyraCom dual-handset telephones are available throughout the hospital, with CyraCom able to interpret over 120 languages on an around-the-clock basis.)

In inpatient and non-emergency settings, LEP patients are provided interpretation services within twenty minutes of a request for an interpreter, and, in the case of emergency department visits, within ten minutes. Additionally, NBHN has translated, or is in the process of translating, numerous key documents used by LEP patients into the predominant languages encountered by the facility. Where needed, NBHN will provide an LEP patient with oral interpretation of written documents. Bilingual call center triage nurses are also available to answer LEP patients' treatment-related questions by phone.

#### *Patient Navigator Program*

The Patient navigator program incorporates interpreter services into a program staffed with nine bilingual staff called Patient navigators, (who speak Spanish, Polish, French and Creole) who are responsible for optimizing the level of customer service experienced by patients and visitors. Stationed at the front lobby information desk and in the medicine, Ob/Gyn and pediatrics clinics, the patient navigators greet patients, issue visitor passes, give directions, provide information, and serve as liaisons to other departments (including patient relations) in assisting in the resolution of issues to the satisfaction of the patient.

In addition to instituting the Patient Navigator Program that allows LEP patients to effectively navigate the hospital's physical plant and services, NBHN has invested in translated directional signage; posted translated signs informing LEP patients of the language assistance services available to them; translated and posted the New York state patients' bill of rights, including procedures for filing complaints; and provided information kiosks and plasma screens displaying important information in multiple languages. The hospital is also committed to an ongoing monitoring and evaluation process designed to determine the overall effectiveness of the LEP language access program. This process includes ensuring adequate documentation and analysis of services provided, conducting patient and provider satisfaction surveys, and investigating and resolving any complaints patients may make about the language assistance services they receive. In addition, NBHN actively solicits comments from patients, providers and the public on how its LEP policies and procedures may be improved.

#### *Interpreter Staff Development and Training*

To ensure that interpreters and Patient Navigators are properly trained and perform professionally when interpreting for LEP patients, the NBHN training department and patients relations department contracted with The Center for Immigrant Health/New York University school of medicine to conduct the medical interpreter's skills training program. This program began with a three-hour screening process to assess the student's proficiency in English and Spanish. Those employee trainees who were selected then participated in a program consisting

of 48 hours of training in cultural, medical and ethical issues related to interpretation and medical terminology.

Trainees practiced the skills taught by participating in role-plays with feedback from the instructors and other participants. Audio and videotapes were used to allow the participants to evaluate and correct their errors. Trainees were given exams after each three-hour class on the medical terminology and actual use of the interpretation skills. At the end of the course, a final written and interpreting skills examination was administered to each participant.

NBHN is now exploring staff development programs for interpreters of other commonly spoken languages, such as Polish, French and Chinese. In partnership with other NYCHHC networks, NBHN is reviewing the resources offered by the medical translation and interpretation training from City University of New York/Continuing Education at Hunter College, which offers a 64-hour program that will include translation of written materials.

<i>NBHN Estimated Customer Service and LEP Expenditures for FY 2003</i>	
<u>Personnel Costs (25.4 percent Fringe)</u>	
4 Patient Representatives/Interpreters	\$230,000
14 Customer Service Coordinators (Navigators)	\$540,163
LEP Coordinator	\$ 60,000
<b>Subtotal</b>	<b>\$860,163</b>
<u>Other Non-Personnel Costs</u>	
Language Assessment/	
Medical Interpreters Training	\$ 40,000
Cultural Diversity/Competency Training	\$113,912
Cyacom	\$120,368
Sign Language Interpretation Services	\$ 48,000
Signage	\$744,277
Translations	\$ 15,000
<b>Subtotal</b>	<b>\$1,081,557</b>
<b>Total</b>	<b>\$1,941,720</b>

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**Parkland Health & Hospital System**  
5201 Harry Hines Boulevard  
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*Corporate Value of Serving a Culturally and Linguistically Diverse Community*

**Background**

Parkland Health and Hospital System, located in Dallas, Texas, is dedicated to making health care available to all Dallas County residents. Parkland delivers more babies each year than any other hospital in the country, and the health system’s network of nine neighborhood-based health centers provides primary care to reduce illness and death rates from preventable diseases in low-income areas.

Parkland Hospital has 711 staffed beds and averages over 42,000 inpatient discharges and nearly one million outpatient visits per year. Over half of the patients seeking inpatient care at Parkland Hospital are covered by Medicaid and another 28 percent are uninsured. Of those seeking ambulatory care services, 57 percent are uninsured and 15 percent are covered by Medicaid.

Dallas County has a population of over 2.2 million people. Over half of the population can be classified as minority, with African Americans comprising 20 percent of the population and Latinos comprising 30 percent. Asians comprise almost 4 percent of the population. More than one in four county residents reside in Spanish speaking homes.

**Overview**

Parkland’s commitment to delivering culturally competent care is reinforced by its mission to provide high-quality, low-cost medical, hospital and other health-related services to all in a manner that is consistent with the patient’s needs, values and recognized belief system. Because Parkland Health & Hospital System has historically treated a diverse and largely Spanish-speaking patient population, the idea of providing culturally and linguistically appropriate care is part of the culture of the institution. From its extensive interpreter services program to the infrastructure that Parkland is creating to ensure that patient needs are being met, Parkland’s leadership is committed to instilling cultural competence as an “everyday” value.

**Leadership**

*Cultural Competence as an “Every Day” Value*

All new employees at Parkland are introduced to the concept of cultural competence during a two-day new employee orientation program. The program begins with a presentation by the chief executive officer or other member of the senior management team on “who Parkland is” and “who Parkland serves.” Through this presentation, the leadership sets the stage by articulating the values and culture of the organization and its commitment to its diverse patient population. The fact that these messages are conveyed directly by a member of the health system’s senior management team emphasizes the importance of cultural competence as an “everyday” value. The theme of cultural competence is also woven into various sections of the

orientation program through role-plays and discussions about culture, stereotypes and customer service.

Parkland Health & Hospital System has also institutionalized cultural competence by including it among the health system's house standards. The house standards are a set of principles that guide employee actions. The principles include such basic actions as dressing professionally, protecting patient privacy and confidentiality, and various other customer service responsibilities. One of the house standards requires that all employees "be culturally competent." This cultural competence standard specifically requires employees to "be aware of differences in values, cultures, beliefs and age" and to "treat everyone with dignity and respect."

The house standards are covered in depth during the new employee orientation and are posted prominently throughout Parkland Health & Hospital System in both English and Spanish. In their annual performance reviews, employees at all levels of the organization are evaluated on how well they meet the house standards. The fact that cultural competence is one of the house standards underscores the fact that this value is a high priority for the organization.

#### *Language Incentive Program*

Parkland Health & Hospital System has many bilingual staff, and it makes effective use of this resource by offering incentive pay for employees who pass an oral Spanish test administered by the human resources department. The intention of the program is not to provide a source of medical interpretation, but rather to identify employees who can help patients and visitors with basic directions or simple instructions in Spanish. The program is not mandatory, but employees who choose to participate and pass the language assessment receive an additional 25 cents of compensation per hour worked.

Employees interested in the language incentive program can sign up for the language assessment during the new employee orientation. The assessment is approximately 15 minutes long and is designed to assess an employee's conversational Spanish skills. The first part of the assessment consists of a conversation during which the employees answer questions such as where they learned Spanish, how many years of Spanish language classes they have taken, what sorts of duties they perform at the hospital, and how speaking Spanish is helpful in their job. The next section of the exam consists of listening to 10 statements, generally questions commonly asked by patients, and translating them to Spanish. A sticker is placed on the hospital badge of employees that pass the examination to indicate to the Spanish speaking population that the individual speaks Spanish.

Once they pass the test, employees sign an acknowledgment that they understand the scope of interpreting that they can provide legally and that they understand the consequences of overstepping those bounds. Program participants are only to use their language skills to assist patients with directions, help with the completion of forms or provide other simple instructions. Any medical terminology that they interpret must be within the limits of their medical education. The acknowledgement states that if employees provide any medical interpretation, they can be subject to any legal suit that is brought against the hospital as a result of their action.

The language incentive program has been offered since 1995 and has been very popular at Parkland Health & Hospital System. Approximately 75 percent of the health system's 1,250 Spanish speaking employees have passed the language assessment and currently participate in the program. By identifying these individuals, the health system has the opportunity to educate them about the types of interpretation that they are qualified to provide. The process has also helped patients by making it easier for them to identify hospital staff who speaks their preferred language. On a large campus such as Parkland's, this can be invaluable for a non-English speaker trying to navigate the system.

## **Interpreter Services and Infrastructure**

Parkland Health & Hospital System's Patient Relations Department handles all interpreter requests on the hospital campus, including any requests in the inpatient medical and surgical departments, the emergency department, or the onsite outpatient clinics. The patient relations department employs 31 interpreters and has an annual operating budget of \$1.5 million. The majority of interpreter requests are for Spanish interpreters, although interpreters are also available for Chinese, Cambodian, Vietnamese, and Laotian requests. Interpreters are available 24 hours a day, seven days a week. The health system also has contracts with two language lines that can be reached from any in-house phone by dialing a dedicated extension. Sign language interpreters are available through a contracted agency.

In addition, Spanish on-site interpreters are available in the women and children's services area and the community oriented primary care clinics during their hours of operation. These areas also have access to the telephone interpreter systems and sign language services.

### *Needs Assessment*

Parkland's patient relations department continuously monitors interpreter use and productivity in order to ensure that the department can meet the needs of the patient population. This monitoring began approximately three years ago, when the departmental administrator first assumed her current role, but has continued as an ongoing activity. The process has had many positive results, including helping to provide evidence about the need to hire additional interpreters, identifying demand trends (which has helped in making staffing decisions), and reducing interpreter response times.

To complete the initial needs assessment, the departmental administrator required interpreters to log each of their encounters for a two-week period, recording the types of interpretation they were doing and how long each took. From this, she determined the major categories of interpretation (e.g. discharge planning, patient teaching, medical history, hospital admission) and the average length of each type of encounter. For another two weeks, interpreters were asked to keep track of the amount of time they spent interpreting within each category, which allowed the administrator to validate her time estimates. In making these time estimates, she took into account travel times for interpreters so that the time standards were an accurate representation of what was involved in providing the services. The information collected was used to determine the number of full time interpreters needed, which resulted in the hiring of 15 additional interpreters. This analysis also allowed the department to identify trends, such as a dip in the

number of requests for interpreters during evening shifts and greater demand during the morning shifts resulting from the scheduling of medical rounds and discharges.

Currently, interpreters keep a daily log of their encounters and report statistics on their encounters and response times on a bi-weekly basis. The amount of time spent on each category of interpretation is revalidated every 3 to 6 months. This tracking mechanism has helped lower the average response time from 60 to 90 minutes to an average of 15 to 20 minutes.

### *Medical Record Sticker System*

Parkland Health & Hospital System routinely documents interpretations in patients' medical records. Interpreters do this by adhering a sticker to the medical record that indicates the interpreter's name, identification number, the type of interpretation provided, the date, and the interpreter's signature. This sticker is placed in the progress notes section of the medical record. Prior to the implementation of this system, the patient services department relied on medical staff to document the provision of interpreter services, which often did not occur. This system provides an easy and thorough way to document interpretations.

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**University of Medicine and Dentistry of New Jersey – University Hospital**  
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*Organizational Strategy for Serving a Culturally and Linguistically Diverse Community*

## **Background**

The University of Medicine and Dentistry of New Jersey (UMDNJ) – University Hospital is located in Newark, New Jersey. The origins of the present day University Hospital can be traced to the 19<sup>th</sup> century with the opening of City Hospital in 1882. Over the years the original structure was moved, enlarged and renovated and in 1968 the state of New Jersey created the College of Medicine and Dentistry of New Jersey (NJCMD), merging it with the medical school of Rutgers University. The establishment of the new school in Newark, New Jersey was based on agreements, known as “The Newark Agreements,” that the University establish and maintain close community ties and provide care to the citizens of Newark. University Hospital’s mission “to improve the quality of life for all those we touch through excellence in patient care, education, research and community service” has its origins in these agreements.

University Hospital has almost 500 total beds and provides over 18,000 discharges and almost 360,000 outpatient visits a year. Located in Essex County, Newark’s population is 40 percent African American, 38 percent white, 16 percent Hispanic, and 4 percent Asian. Other populations such as Asian American and Pacific Islanders are growing in numbers in the city. The most common languages spoken by patients with limited English proficiency are Spanish, Portuguese, French, Polish, Arabic, Haitian Creole, and French Creole.

## **Overview**

Cultural competence practices at UMDNJ - University Hospital are integrated into all aspects of operations. The hospital’s commitment in this area can be seen in a variety of ways. The leadership of University Hospital, CEO, senior staff, faculty, and its community board are key to the implementation of cultural competence practices. Four key operational areas demonstrate the impact of leadership at University Hospital in implementing cultural competence practices: strategic planning, staff recruitment and training, customer service and patient satisfaction, and community outreach.

## **Leadership and Strategic Planning**

Many NAPH members have put some form of cultural competence into practice. In each case, the influence of the institution’s leadership is evident whether the practices are in their early stages or are well established. University Hospital’s CEO, Sidney Mitchell has led University Hospital’s development, implementation, and evaluation of culturally competent health care. Mr. Mitchell and his leadership team, including senior staff and the governing boards, believe that a workforce that reflects the community is necessary to providing quality care to patients who are residents of the community. Diversity in the workforce, supported by similar medical school policies and initiatives, provides the necessary environment for the delivery of culturally appropriate services to a diverse patient population.



University Hospital works closely with other UMDNJ affiliates such as the Office of Affirmative Action and Equal Employment Opportunity and the Institute for the Elimination of Health Disparities in strategic planning, development, training, and new initiatives in cultural competency. For example, the Institute for the Elimination of Health Disparities, a statewide research initiative led by the UMDNJ School of Public Health, brings together the research, education and community outreach programs conducted at the five academic campuses of UMDNJ throughout the state of New Jersey.

In its first year, the Institute initiated collaborations with University Hospital, community, and governmental organizations in Newark and Camden, the two cities with the greatest health disparities in the state. As part of its focus, the Institute addresses issues of quality and access by the various communities served by the hospital through research and through the development of intervention strategies. Similarly, the Office of Affirmative Action and Equal Employment Opportunity was recently awarded the Alan and Joan Bildner Foundation Diversity initiatives grant to develop cultural competence standards for the entire university community including physicians, residents, and faculty. University Hospital physicians and faculty are part of the project team working on developing these standards.

Lastly, University Hospital has appointed faculty with expertise in cultural competency to serve on its advancement team, a team that looks at ways to strengthen community relationships through culturally appropriate strategies.

### **Staff Recruitment and Training**

One of the tenets of UMDNJ's commitment to cultural competence is the belief by hospital leadership that efforts in this area must be persistent; if the initiative is sporadic, it will not be effective. In order to ensure that this commitment is operationalized, one of six strategic goals at the University level is to develop a relationship between the community and the cross-training of employees. This is done formally in the following manner:

- The hospital established hiring targets as part of its strategic planning process to ensure a diverse workforce. Attention to cultural competence is part of all hiring practices and is incorporated into the job description of new employees. As part of staff recruitment the hospital has instituted a school-to-career program that holds meetings at Newark schools to encourage students to consider a health career. The program provides internships and training to selected students.
- The affirmative action office brings a cultural competency-training program directly to each unit in the hospital every several years. The program developed as a result of mandatory workshops that are held to cover how various cultures solicit and receive health information.
- UMDNJ also offers a non-mandatory cultural competence training workshop for staff. Many of the hospital's employees have attended these sessions, and the hospital's leadership is considering offering incentives to encourage even more employees to

attend. Supervisors support the program and encourage staff to attend. The results of the workshop are being marketed extensively within the hospital. The following is a description of the course:

*This specialized, non-mandatory workshop is an interactive session that encourages awareness, knowledge and skills development around cultural and diversity-oriented issues during patient interventions. The workshop also explores areas of workplace conflict and cultural collisions that develop due to lack of cultural knowledge, tolerance and respect, and shows how miscommunication and misunderstandings arise due to cultural communication style differences. Competency strategies are presented through dialogues, videos, role-plays, individual and group exercises and case studies.*

- The hospital received funding from the Office of Minority and Multicultural Health in the New Jersey Department of Health and Senior Services to develop a medical interpreter curriculum to train all of its volunteer medical interpreters in cross cultural communication. This initiative, led by Dr. Debbie Salas-Lopez, Chief of the Division of Academic Medicine, Geriatrics, and Community Programs, has resulted in the publication and availability of a medical interpreter curriculum called *Bridging Language and Culture in Health Care Communication* that can serve as a best practice model in health care institutions throughout the state. New Jersey is now considering making the training and certification of hospital medical interpreters mandatory.

### **Customer Service and Patient Satisfaction**

Cultural competence is closely linked to customer service and patient satisfaction at UNDMJ. According to one senior staff member, “Everyone knows the customer’s perception of service is #1 in the hospital.” The hospital has adapted the Press Ganey survey to measure patient satisfaction with special attention paid to those elements of the survey related to cultural competence.

Findings from previous patient satisfaction surveys showed that many patients felt that they were unable to resolve problems in a timely manner. As a result a patient advocacy program was established, and a Spanish-speaking patient advocate was hired. At present staff morale is noticeably better and patient satisfaction has improved on eight key indicators, with seven indicators in the top 10 percent.

Work is currently underway at UMDNJ to standardize data collection by race and ethnicity. The patient advocacy office is developing accountability measures as part of customer service improvement and the general attention given to quality of care.

### **Community Outreach**

University Hospital conducts extensive outreach efforts with the surrounding community. In 2002 the hospital held 50 health fairs, 20 stroke lectures, and a dozen other lectures on various health topics relevant to our community’s health care needs. Hospital employees are present at

these community events and primary reading materials are made available on cancer, diabetes, heart disease, stroke, and other health conditions in English and Spanish.

Although the celebration of various cultures and outreach to the community at large is important, University Hospital is also targeting cultural competence issues that relate to the special health needs of particular populations, such as the Latino community. A Latino medical conference, “Our Health Our Culture” was held in 2002 in collaboration with the state of New Jersey’s Office of Minority and Multicultural Health. Key Latino hospital faculty work closely with the State of New Jersey in Latino health initiatives such as, the Latino Health Summit, the Governor’s Hispanic Advisory, and the Office of Minority and Multicultural Health Commission.

In 1999 under the leadership of the Department of Medicine, Focus Community Health Center was established as an ambulatory site to address the needs of the growing Latino community in Newark. Staffed by bilingual, bicultural physicians and health care professionals, the Center is rapidly becoming a model for the delivery of high quality clinical care, culturally appropriate education for students and residents, and community based research. Recently, the health center received funding to establish the Latino Diabetes Education and Prevention Center at the Focus to deliver culturally appropriate diabetes care. A certified bilingual, bicultural diabetes educator counsels patients on diabetes preventive care, nutrition and coping strategies. In addition to Focus Community Health Center, University Hospital supports ambulatory practices that serve other communities of color. For example, University Physicians at Vailsburg, a health center in the Vailsburg section of Newark, serves a large Haitian population.

Part of the hospital’s long-term goals is to continue to increase access to health care services by working closely with the surrounding community. Initiatives that include home health care for the fragile elderly of Newark, on-site hospital support at local community based organizations, and establishing community health kiosks in public places are part of University Hospital’s new goals.

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# **Focus Group Summary**

**NAPH EXECUTIVE FOCUS GROUP  
ON CULTURAL COMPETENCE IN HEALTH CARE**  
NAPH Fall Conference, Washington DC  
October 10, 2002

**CEO Focus Group Discussion Summary**

**Focus Group Background**

This focus group discussion is part of a project by the National Public Health and Hospital Institute (NPHHI) to produce a compendium of promising practices, envisioned as a toolkit for practitioners, support staff and administrators in health care facilities in order to provide culturally and linguistically appropriate services (CLAS) to diverse populations.

The Focus Group session engaged senior level executives of public hospitals and health systems in a two-hour facilitated discussion about their respective visions and leadership strategies for designing, implementing and maintaining cultural competence in their respective organizations.

Below is a brief summary of the discussion highlights. Comments are not attributed to individuals.

**Focus Group Participants**

Ron J. Anderson, MD  
President and CEO  
Parkland Health & Hospitals System  
Dallas, TX

Patricia A. Gabow, MD  
CEO and Medical Director  
Denver Health  
Denver, CO

Robert J. Baker  
President and CEO  
University HealthSystem Consortium  
Oak Brook, IL

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Executive Director  
The Health and Hospital Corporation of  
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Indianapolis, IN

David E. Jaffe  
CEO  
Harborview Medical Center  
Seattle, WA

William B. Walker, MD  
Director  
Contra Costa County Health Services Department  
Martinez, CA

The staff of the contracted facilitator, RESOLVE, included Abby Dilley and Sara Litke.

### **Introduction and Agenda Review**

Ed Martinez, co-principal investigator for this project and an assistant vice president at NAPH, welcomed the focus group members to the discussion and thanked them for their participation. He explained that the focus group is part of a larger project sponsored by OMH to advance cultural competence efforts and strategies.

Facilitator Abby Dilley reviewed the agenda and outlined the discussion objectives:

- Gain insights into how cultural competence efforts are developed, implemented and managed at diverse, complex organizations represented by participants
- Identify key leadership components for advancing these efforts
- Determine appropriate next steps for accumulating additional information for advancing cultural competence, as well as for the development of the tool kit for practitioners, support staff and administrators

After brief introductions, participants determined a few basic ground rules for their deliberations and then proceeded with the agenda.

### **Visions of Cultural Competence**

Participants shared examples of how cultural competence will be reflected in their organization's core mission at the daily practice level in five years. One participant said her vision is outcome focused and is equal health for all in the community served. Many other participants agreed with this vision. Most of the other comments regarding the future reflection of enhanced cultural competence were related to more effective provision of health *care*, or the process by which equal health outcomes can be achieved. Two broad, inter-related themes of these comments are 1) cultural competence permeates staff at all levels throughout the organization, and 2) all patients are treated with respect and as effectively as possible. A fundamental component of accomplishing this second goal is enhancing understanding of and response to patient needs that are culturally related. Participants' comments suggested other components of this goal as well, such as having a diverse staff and appropriate tools for understanding the community and communicating with individual patients. Comments made during this portion of the agenda are captured below under general themes.

*Equal health for community served.*

- Equal health is achieved for the entire community served.
- Racial disparities are recognized; racism is acknowledged and addressed.

*Cultural competence permeates staff at all levels throughout the organization. Actions contributing to achieving this goal include comprehensive training of all staff and an increase in staff diversity.*

- The program is fully institutionalized. It is fully embraced by every employee. The energy and focus of the program is maintained. All professional staff is trained, and, ultimately, training is provided at all levels for all staff members, including building maintenance staff. Because everyone who works at the hospital has an opportunity to come in contact with patients and, therefore, influence a patient's experience at the hospital, everyone should receive training.
- We have moved beyond cultural sensitivity (i.e., "I mean well") to cultural competence (i.e., "I am doing well for the patient"). Staff receives mandatory orientation on cultural competence beyond a superficial level to foster real understanding, which translates to better care and improved health outcomes.
- People believe that not addressing cultural competence is bad medicine.
- Orientation of all staff goes beyond basic cultural competence.
- There is a waiting line of qualified candidates whenever a position is advertised.
- Cultural competence is not just talked about but lived, with the example set from the top of the organization on down throughout the entire staff.
- A range of expertise assists with developing cultural competence (e.g., medical anthropologist).
- All care providers are bilingual, as linguistic competence is essential to cultural competence.
- All of the direct care staff has the tools to best communicate with and serve the patient population. This goal goes beyond having a diverse staff because the diversity of staff can never match the diversity of the changing patient population.
- Information is presented appropriately so that people can understand their options and make informed decisions.
- A greater number of care providers represent the Latino population, the largest population served by the organization.
- There is more diversity throughout the staff and organization levels. This goal is a challenge and may require dedicating slots for diversity or broadening of training and education programs from which staff are recruited.



*All patients are treated with respect and as effectively as possible. Component of accomplishing this goal is enhancing understanding of and response to patient needs that are culturally related. Some sub-themes emerged in the discussion and include the following:*

All patients are treated with respect and receive high quality services

- The focus of care is on common needs of patients that exist across cultures, such as the interest of all patients to be listened to, understood and treated respectfully.
- Relationship-centered care is the fabric of the institution and provides an advantage over the competition.
- All who access health care receive high quality services based on respect and responsiveness.
- The focus is on respect and responsiveness. All patients from all backgrounds (e.g., cultural, religious, economic) are respected.

The demographics of the community are understood

- The demographics served by the organization are continually reviewed so that the organization anticipates changes in the community.
- The needs of individual patients are understood.
- The assessment process for patients includes information on cultural beliefs.
- Care of patients demonstrates an understanding of and action on feedback from the people served and is sensitive to what they want, according to their culture and upbringing. Care providers are respectful in actively seeking input.
- Care providers respect patients as individuals. Providers avoid inadvertently developing stereotypes that hinder care based on cultural information intended to enhance care (e.g., Asian women consider making eye contact a sign of promiscuity).
- Care providers are able to work with individuals more effectively by understanding and taking into account the individuals' needs, including those that are culturally related.

## **Key Leadership Tools and Strategies**

Participants shared their ideas on the key leadership tools and strategies for integrating cultural competence into their organizations' core mission during 1) planning and development and 2) implementing, managing, and sustaining cultural competence. The comments are arranged below by general topics. Some of the comments can be summarized in general strategies within and across topics:

### **Planning and Development**

#### Highlighting Cultural Competence as a Priority

- Recognize the problem – disparity of health outcomes – and then highlighting it as a priority issue to be addressed.
- Engage people who have a particular sense of the specific community.
- Engage people who have tools to reach out to the community.

- Survey and respond to the community continually, and think of additional ways to gather information effectively.
- Engage managers and staff in creating the solutions.

### Data Gathering and Outreach

- Utilize existing programs and consider innovative approaches to train and recruit within the community.
- Engage community organizations and utilize community activities for information sharing and gathering.
- Continually scan the community. Given the time lag of the census, advisory boards and other mechanisms provide valuable information on what is happening in the neighborhood and who is joining the community.
- Interacting with new groups in the community and letting them know what services are provided should be part of the business model.
- Outreach is not easy, but investment for the long term pays off down the road. Going out into the community and listening to and embracing the unique characteristics of their respective health care delivery is important.
- A neutral format for providing input is important, such as hiring an objective third party to work with an advisory committee or conduct surveys.
- Recognize that staff may be more in tune than management on some issues and can provide important input.

### Evaluation

- Identify where the key area for change is within the organization.

### Tapping Diverse Expertise

- Mentors can be helpful (e.g., an African American minister from the community warns the hospital administration of potential pitfalls).
- Planning is critical and should tap lots of resources (e.g., medical anthropologist, advisory group).

### Dedication of Resources

- Investment in other community initiatives and activities (e.g., housing, economic) can benefit health care efforts.

### Fostering Leadership

- Empowering a committee of staff members to create and implement cultural diversity activities has helped to address issues that were being raised by staff.
- Diversity training conducted by a consultant group as an off-site retreat, first involving managers and then managers and staff together by departments to create a shared learning experience.
- Being open to making changes and “slaying some dragons” is essential. Involve managers and staff in creating the solutions for and with each other.
- Leadership development is important.

## **Implementing, Managing, and Sustaining Cultural Competence**

### Training and Recruiting

- An AmeriCorps program recruits throughout the community and provides bilingual training to serve as medical interpreters and community liaisons.
- The Disney program provides training in the Disney method of customer service, which focuses on respect for individuals.
- Cooperative ventures with high schools (e.g., having a high school on the hospital campus) can encourage the interest of students from the community in health care professions.

### Outreach

- Getting out from behind the hospital walls is essential. Community events and religious institutions can provide opportunities to screen individuals and inform them of health care services.
- Community focus programs are a way to reach out to the community proactively and learn from them. Making the sessions as comfortable as possible for participants and providing assistance (e.g., childcare, transportation) encourages participation.
- Fun approaches can be effective—celebrating while educating (e.g., festivals, storytelling, sharing favorite foods).

### Increased Accessibility

- “Patient navigators” (preferably who speak the same language as the patient) can help individuals get around the hospital and communicate more effectively.
- Computer kiosks can provide maps and “who’s who” information in multiple languages.
- The design of signs should be improved and the content should be reviewed to be sure of the message it conveys in a given language or dialect.

- Consider multiple tools to help patients navigate around the building and among care providers.

### Professional Development, Training, and Performance Reviews

- Cultural competence should be a factor in performance evaluations and compensation.
- Closing the feedback loop is important. Tools for helping individuals and the organization understand where they are failing in human interaction include “mystery shoppers,” rapid feedback from surveys and monthly one-on-one open-door sessions with the CEO.
- Investing in clerical staff is important since they are the front-end people. Having new clerical staff attend “Clerical Academy” for a full week has been useful. As one component of the training, participants serve as “mystery shoppers,” which teaches them a lot about what it is like to be on the other side of the desk.
- It is important to recognize that sometimes patients are pretty tough and do not treat staff well. Staff may respond in kind because they feel they have no options. Training can provide them with options and help them feel safer.

### **Clinical Services and Outcomes**

Participants shared comments on cultural competence in clinical services and outcomes. A common theme of many of the comments was the need to incorporate cultural competence into the training of caregivers, beginning at medical school and continuing during residency. A second theme was the need for research to involve a greater diversity of people.

### Students and Training

- Cultural competence must be part of medical school curricula and training. We need to think about training people differently; not many of the points discussed in this session are currently part of training for medical professionals. Training needs to involve developing a broader skill set.
- Attending physicians also need to recognize their role as mentors in regard to being respectful and responsive to patients, and management needs to emphasize with attending physicians that cultural competence must be part of the training they provide.
- Medical students with language skills and diverse backgrounds must be sought out and given opportunities.

### Research and Best Practices

- Some changes are underway. For example, some transplant programs now proactively transplant organs back to the population of the donor. Another example includes the National Cancer Institute (NCI), which now requires that cancer research must mirror the make-up of the community in which it is conducted. More efforts need to include diverse populations in clinical trials and studies.
- If the goal is state-of-the-art care with the premise of no disparities among patients, then we must continue to support clinicians in regard to best practices. To develop best

practices for all patients, clinical trials must be inclusive and not just involve the traditional majority.

### **Other Comments**

- Most people do want to be good caregivers and do want to be good to patients.
- The role of patients' families is important. It is important to have someone close to the patient involved in his or her service.
- It is important to recognize that medical translation requires ability beyond day-to-day language skills. Also, family members often interpret rather than translate for the patient. These issues apply to sign language as well as spoken language.

### **Next Steps**

Participants shared the following comments on how to advance culturally competent health care and, in particular, what NAPH could do to assist these efforts:

- If they are serious about addressing class and minority issues, government agencies need to get organized and create funding. The NAPH executive committee should work with the federal agencies to help them understand the differential impact cultural competence requirements have on public hospitals compared to private hospitals. A more effective way than lawsuits needs to be found to address these issues.
- More discussion is needed about what cultural competence is. It is a continuous effort to change to meet rising expectations. Realistically, consideration must be given to what is reasonable versus what is ideal. NAPH should encourage these discussions among key decision makers.
- NAPH could conduct trainings and help to gather and share information on best practices.
- NAPH could help to quantify the costs associated with these activities.
- NAPH could help with guidance on interpreting and implementing the National Standards for Culturally and Linguistically Appropriate Services (e.g., information on the state of the art of various translation options such as video and telephone services).

# **Proposed Toolkit Content and Development**

## **Proposed Toolkit Content and Development**

The following reflects proposed toolkit content, structure, and format in addition to an estimate of resources needed to produce a high quality product:

- **Areas of Toolkit Focus: Leadership, Language Services, Community Outreach, Planning & Monitoring, Customer Service, Infrastructure, Clinical Services**
- **Examples of Toolkit Content:**
  - **Index/table of contents** will have an index for each section of the toolkit so that users can easily identify information they are looking for;
  - **Preface** will include: the purpose, scenarios of use, types of users, the goals and the concrete strategies for achieving different aspects of an organization that provides culturally and linguistically appropriate care. The purpose of this toolkit, which differentiates it from other similar efforts, is to address the specific “how, what, when, and where” of integrating cultural competence into the management and operations of a health care facility. This includes being able to recognize and respond to the differing health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy seen across divergent populations;
  - **Demographic information** that will assist in creating a business case for integrating cultural competence into health care systems and in addressing the issue of health care disparities. There are specific methods or sources of information that senior leaders of hospital and health systems need to use to determine the cultural factors related to patient needs, attitudes, behaviors, health practices, and concerns about using health care services among their patient populations. Potential strategies and sources of information might include: marketing, enrollment, and termination figures; census figures and adjustments; voter registration data; school enrollment profiles; focus groups, interviews, and surveys; county and state health status reports; data from other community agencies and organizations; collaboration and consultation with other community-based organizations, providers, and leaders on outreach, building provider networks, providing service referrals, and enhancing public relations; community-member participation on hospital governing boards, community advisory committees, ad hoc advisory groups, and hospital-community meetings;
  - **Examples of Leadership and Programmatic Strategies** derived from case studies. This section will outline how senior leaders can leverage available financial and infrastructure resources to better improve how hospitals and health systems provide culturally and linguistically appropriate care. Senior management’s role includes providing all staff with the tools they need to

effectively communicate and care for diverse patient populations in a safe and quality manner. These tools include: (1) a clear and unambiguous understanding of their institution's goals, policies, and values regarding the provision of culturally competent care; (2) training and human resources development activities that foster a "real" and comprehensive understanding of their specific service area's cultural and linguistic health care needs; and (3) high-quality and easily accessible interpreter and translation services. Senior leaders are also responsible for providing the infrastructure, financial and morale-building supports necessary for staff to acquire these tools;

- **Quick reference guide to laws, regulations, and guidelines** that apply to equal access to health information and services for limited English proficient (LEP) and other vulnerable populations from sources such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee on Quality Assurance (NCQA), DHHS Office of Civil Rights (DHSS/OCR), and Centers for Medicare & Medicaid Services (CMS);
  
- **Model program designs** that will include information that is customized for all levels of organization (executive leadership, program operations and clinical services) in a health care facility. The goal of a tiered toolkit design is to address a multi-faceted nature of serving diverse populations and to integrate cultural competence throughout all levels of the health care organization. Organizational cultural competence requires a substantive understanding of the communities served and the ability to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the organization's service area. Responsive service delivery to a community requires a collaborative process that is informed and influenced by community interests, expertise and needs. Services designed and improved with attention to community needs and desires are more likely to be used by patients, and lead to more acceptable, responsive, efficient, and effective care;
  
- **Model Effective Plans on Language Assistance for LEP Individuals** will be included to reflect strategies for implementing accurate and effective communication between patients and staff - a most fundamental component of the health care encounter. Language barriers frequently lead to misunderstanding, dissatisfaction, and omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. Hospitals and health systems are required to inform patients that they have the right to free language services and to ensure that such services are readily available. Effectively serving diverse populations requires that interpreter services be available and provided by trained and competent bilingual staff or medical interpreters, and that written materials be available and translated in a manner that accurately and appropriately conveys the meaningful substance of the document or sign being translated. In accordance with current DHHS/OCR guidance, model plans for implementing language assistance incorporated in the proposed toolkit will be a practical and experience-based "walk-through" for providers and will include: (1) Identifying LEP persons



who need language assistance; (2) Language assistance measures; (3) Training staff; (4) Providing notice to LEP persons; and (5) Monitoring and updating the LEP plan;

- **Development and budgetary strategies** section will incorporate information on how to create an effective, long-term program. Start-up and maintenance costs will also be addressed for the benefit of executive leadership and program operations. The costs involved in developing and conducting culturally competent activities in health care organizations will be outlined as a tool for senior staff members to estimate budget concerns;

Embedded within effectively providing culturally competent care in a health care setting are a number of prerequisite infrastructure and organizational supports. These include: information systems to assess perpetually changing community demographics and gauge utilization; mechanisms to access and obtain meaningful community input on service needs; systems to effectively assess organizational capacities, strengths and weaknesses (e.g., monitoring/evaluation tools and quality improvement mechanisms); a diverse workforce and leadership that is representative of the organization's service area; structures and procedures that support easy access to high-quality translated written materials and interpreter services; policies and procedures that provide staff with a clear and unambiguous understanding of their institution's goals and values regarding the provision of culturally competent care (and their individual role in providing such care); and the financial resources and budget allocations necessary to develop and provide these tools;

- **Sample policies and procedures** that will outline strategies for implementing culturally and linguistically appropriate policies. The policies will address the role of minorities as a consumer and as an employee. Senior leaders need to ensure that workforce training and education activities provided at their organizations go beyond enabling staff to superficially address the healthcare-related cultural needs of patients. Many staff training programs in this competency area are insufficient and not very helpful in informing staff on how to respectfully seek input from patients on their culturally related health needs. Staff also sometimes perceives cultural competence to be an "extraordinary skill" as opposed to a fundamental component of doing their job well. Personnel training and evaluations at all levels should emphasize moving beyond cultural sensitivity (i.e., "I mean well") to cultural competence (i.e., "I am doing well for the patient"), and regularly make explicit the link between organizational cultural competence, better care and improved health outcomes;
- **Sample translated documents/marketing material**, particularly those vital documents reflected in the provisions of DHHS/OCR guidance and that promote and enhance meaningful access for LEP populations;

- **Case studies** of NAPH hospitals and health systems that describe promising and effective practices in culturally and linguistically appropriate health care;
  - **Key NAPH meeting and forum summaries** that will present leadership components needed to plan, develop and sustain an environment that reflects a belief that serving culturally and linguistically diverse communities is part of the core mission of the organization;
  - **Organizational assessment tools:** A responsive and accountable health care organization requires the monitoring of performance, quality and financial indicators in order to meet the needs of patients, staff and the communities served. Based on current research in the area of managing culturally competent public and voluntary hospitals and health systems, we propose developing a data-based management assessment and monitoring system that provides senior leaders with a timely and meaningful overview of the organization's response to the needs of the diverse communities served. This is envisioned as a data-driven management tool that would facilitate organizational commitment and orientation to providing culturally and linguistically appropriate health care services;
  - **Online discussion section** for executive management from several organizations to communicate with one another. This will provide a forum for NAPH senior leaders to discuss how to continue to better improve ways in which their health systems can provide culturally competent care;
  - **Database of information on cultural competence** relevant to public and voluntary hospitals and health systems, as well as web linkages to key resources. This section will also include a glossary and bibliography. It will also include financial and infrastructure supports for cultural competence initiatives that are currently utilized by select NAPH systems.
- **Proposed Toolkit Format:**
    - Web-based on NAPH homepage
    - Related marketing and instructional material (written and other visuals)
    - Possible CD-Rom version

# **Sample of Home Page Design for Toolkit**



# Serving Diverse Communities in Hospital and Health System Settings

A Toolkit prepared by The National Association of Public Hospitals and Health Systems  
Funded by The U.S. Department of Health and Human Services Office of Minority Health

Mission Statement

Demographics

Leadership/Programmatic  
Strategies

Laws, Regulations, and  
Guidelines

## Model Program Designs

Marketing/Budget

Policies and Procedures

Organizational Assessment  
Tools

Key Meeting and Forum  
Strategies

Sample Translated Documents

Additional Resources



Executive Leadership

Program Operations

Clinical Services



Welcome!  
Please select your  
area of interest.



*SAMPLE OF HOME PAGE DESIGN FOR TOOLKIT*

# **Appendix A: Interview Guides for Case Study Research**

**DHHS OFFICE OF MINORITY HEALTH PROJECT**

*Interview Guide for Identifying Promising Practices*

**FIRST ROUND**

**1. Please describe the programs or activities that best illustrate your organization's efforts in the area of cultural competence.**

Possible Probes:

- Innovative language access or interpreter services programs?
- Community outreach activities?
- Staff development and training activities in cultural competence?
- Collection, analysis, and appropriate use of race, ethnic, and language data?
- Medical and other healthcare professional education?
- Quality improvement efforts with cultural competence as a key component?

**2. How are your organization's values regarding cultural competence made clear to its staff, patients, and the community it serves?**

Possible Probes:

- Policies and procedures related to cultural competence? Process and people involved in development? Community input?
- Budgetary allocation for cultural competence initiatives? Component of strategic planning or business plan development?
- Key person coordinating cultural competence activities of organization?
- Commitment to workforce diversity?
- Process and individuals involved in mission statement development?
- Availability of translated documents? Translated signage? Marketing and educational materials?
- Staff performance evaluations or incentives related to cultural competence efforts?

**3. How does your health care system plan, monitor, and evaluate the health care needs of the various patient populations it serves?**

Possible Probes

- Community needs and organizational self-assessments regarding cultural competence?
- Partnerships with other community-based resources to identify cultural and linguistic needs of community?
- Data sources and systems used to collect, manage, analyze, and appropriately use cultural-competence related information?

**4. Please tell us about the systems currently in place at your organization for insuring access to interpreter services for limited-English proficient patients.**

- Acquisition, training, and testing of staff interpreters and bilingual staff?
- Staff training on use of interpreters in medical setting?
- Innovative uses of technology to aid interpretation in medical settings?

**5. What is the nature and scope of your health care system's staff development and training activities in the area of cultural competence?**

- Assessment of staff's cultural competence skills?
- New employee orientation program? Continuous training or in-services on cultural competence?
- Tailored cultural competence programs for different hospital staff?

**6. Please describe how your organization's systems and infrastructure support its goals in the area of cultural competence.**

Possible probes:

- Use of information technology systems to collect, analyze, and appropriately use race, ethnic, and language information?
- Any cultural competence link to medical and other health care professional education training?
- Key person or department to coordinate all cultural competence activities within system?
- Use of signage, décor, or physical environment to make hospital setting more welcoming?
- Grievance procedures for addressing lapses in cultural competence?

**7. Have we discussed everything you think important for us to know in order for us to understand your organization's strengths in the area of cultural competence?**

## **DHHS OFFICE OF MINORITY HEALTH PROJECT**

### ***Interview Guide for Identifying Promising Practices***

#### **SECOND ROUND**

#### **Organizational Values/Leadership**

How and in what venues (e.g., policy and budget decisions) does your CEO try to articulate and/or demonstrate your organization's level of commitment to cultural competence to staff, patients, and community?

#### **Clinical Services**

1. How do clinicians at your institution:
  - a. Provide an environment in which patients from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options?
  - b. Encourage patients to express their health beliefs and cultural practices and, where appropriate, integrate those approaches into treatment plans?
2. What were the costs involved in developing and implementing these activities?
3. What organizational barriers needed to be overcome and how were they addressed?
4. What actual or perceived benefits have been seen as a result of these activities?

#### **Planning, Monitoring, Evaluation**

1. What methods and information sources in the community (both formal and informal) does your institution use to retrieve and update data on the needs of the different racial and ethnic groups in your service area?
2. Specifically, how do you use this information to plan for, develop, and implement services that are responsive to the cultural and linguistic needs of their service area?
3. What were the costs involved in developing and implementing these activities?
4. What organizational barriers needed to be overcome and how were they addressed?
5. What actual or perceived benefits have been seen as a result of these activities?



## **Staff Development**

1. What workforce training and education programs do you offer to your staff in the area of cultural competence?
2. How does your organization organize its workforce training and education programs to ensure that they:
  - a. Are tailored for relevance to the particular functions of the trainees and the needs of the specific populations served?
  - b. Educate staff on the effects of cultural differences between staff and patients within clinical settings?
  - c. Cover the organization's language access policies and procedures (e.g., relevant laws and how to access interpreters and translated written materials)?
  - d. Successfully train staff on the elements of effective communication between staff and patients of different cultures and languages (e.g., how to work respectfully and effectively with interpreters and telephone language services)?
  - e. Teach staff strategies and techniques for recognizing and resolving racial, ethnic or cultural "conflicts" with patients?
3. How do senior leaders at your institution try to ensure that staff is receiving all the tools they need in this particular area of providing culturally competent care?
4. What were the costs involved in developing and implementing these activities?
5. What organizational barriers needed to be overcome and how were they addressed?
6. What actual or perceived benefits have been seen as a result of these activities?

## **Language/Interpreter Services**

1. How does your organization organize language access and interpreter services to:
  - a. Ensure the availability of interpreters and translated materials?
  - b. Assess and ensure the training and competency of individuals delivering interpreter services?
  - c. Ensure that translated materials and signs accurately convey the meaningful substance of materials written in languages other than English?
2. What were the costs involved in developing and implementing these activities?
3. What organizational barriers needed to be overcome and how were they addressed?
4. What actual or perceived benefits have been seen as a result of these activities?

### **Organizational Infrastructure**

1. What financial and infrastructure supports for cultural competence initiatives does your institution provide for its staff and patient populations?
2. What were the costs involved in developing and implementing these supports?
3. What organizational barriers needed to be overcome and how were they addressed?
4. What actual or perceived benefits have been seen as a result of these activities?

### **Community Outreach**

1. What sorts of community outreach activities does your institution sponsor?
2. What were the costs involved in developing and implementing these supports?
3. What organizational barriers needed to be overcome and how were they addressed?
4. What actual or perceived benefits have been seen as a result of these activities?

# **Appendix B: 2003 NAPH Leadership Forum on Serving Diverse Communities**

**2003 NAPH LEADERSHIP FORUM ON SERVING DIVERSE COMMUNITIES**  
**March 26 – 28, 2003**  
Hilton Head Island, SC

NAPH conducted a day and a half roundtable meeting for leaders at NAPH member hospitals and health systems (CEOs, COOs, Medical Directors, and other senior leaders) to share and discuss management strategies to provide quality healthcare to a large number of minority and immigrant populations with limited-English proficiency and varied cultural backgrounds. This leadership forum focused on how NAPH members are delivering culturally competent care to their increasingly diverse patient populations within an environment characterized by overburdened and constrained financial reimbursement mechanisms. Focused discussions explored how NAPH institutions are: assessing community needs and building community relations, organizing effective workforce training and education programs, improving language access and interpreter services, and developing financial and infrastructure supports for cultural competence initiatives. Guadalupe Pacheco, Public Health Advisor and Special Assistant to the Deputy Assistant Secretary for Minority Health, U.S. DHHS Office of Minority Health presented opening remarks and a national perspective on cultural competence in the safety net.

The following are the agenda and the discussions guides for the Roundtable:

**AGENDA**

**Day One: Thursday, March 27**

- |                            |  |
|----------------------------|--|
| <b>8:30 am</b>             | <b>Welcome and Introductions</b><br><b>Larry S. Gage</b> , President, NAPH<br><br><b>Opening Remarks and a National Perspective on Cultural Competence in the Safety Net</b><br><b>Guadalupe Pacheco</b> , Public Health Advisor and Special Assistant to the Deputy Assistant Secretary for Minority Health, DHHS Office of Minority Health |
| <b>9:00 am – 10:15 am</b>  | <b>Plenary Session</b><br><br><b>Developing a Model for Culturally Competent Care</b><br><b>Barbara Garcia</b> , Director, Community Health Promotion & Prevention, Community Health Network of San Francisco, CA<br><b>Gene O’Connell</b> , Executive Administrator, San Francisco General Hospital, CA                                     |
| <b>10:15 am – 10:30 am</b> | <b>Break</b>   |

10:30 am – 12:00 pm

**Concurrent Breakout Sessions: Discussions on Promising Practices and Initiatives (Select one):**

- **Assessing Community Needs and Building Community Relations**

**Moderators:**

**Samuel L. Ross, MD, MS**, Chief Medical Officer & Sr. Vice President, Parkland Health & Hospital System, TX

**William B. Walker, MD**, Director, Contra Costa Health Services Department, CA

- **Organizing Effective Workforce Training and Education Programs**

**Moderators:**

**Lynda D. Curtis**, Senior Vice President, North Brooklyn Health Network, Woodhull Medical & Mental Health Center, NY

**Steve Mandle**, Vice President Human Resources, Parkland Health & Hospital System

1:00 pm – 2:30 pm

**Concurrent Breakout Sessions: Discussions on Promising Practices and Initiatives (Select one):**

- **Improving Language Access and Interpreter Services**

**Moderators:**

**Loretta Saint-Louis, PhD**, Director, Multilingual Interpreting, Cambridge Health Alliance, MA

**Sherry Steinaway**, Manager, Organization, Development/Community/Training, Harborview Medical Center, WA

- **Developing Financial and Infrastructure Supports for Cultural Competence Initiatives**

**Moderators:**

**John Bluford**, President/CEO, Truman Medical Centers, MO

**Robert A. Burton, Sr. VP**, Chief Administrator, North Broward Hospital District, FL

**Day Two: Friday, March 28**

**9:00 am – 11:00 am**

**Plenary Session**

**How to Lead a Culturally Competent Organization**

**LaRay Brown**, Sr. VP, Corporate Planning, Community Health & Intergovernmental Relations, New York City Health & Hospitals Corporation

**John O'Brien**, CEO, University of Massachusetts Memorial Healthcare System

**William B. Walker, MD**, Director, Contra Costa Health Services Department

**Moderator:**

**Ed Martinez**, Assistant Vice President, NAPH

**11:00 am – 11:30 am**

**Wrap Up and Next Steps**

**11:30 am**

**Adjourn**

## DISCUSSION GUIDES

### *Developing a Model for Culturally Competent Care*

Moderators: *Barbara Garcia, Community Health Network of San Francisco*  
*Gene O'Connell, San Francisco General Hospital*

#### Key Points for Presentation and Discussion

*Culturally competent care includes being able to recognize and respond to the differing health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy seen across divergent populations. It goes beyond language access and interpreter services.*

*Effective care ultimately results in: positive outcomes for patients (including satisfaction); appropriate preventive services, diagnoses, and treatments; adherence to prescribed treatments; and improved health status.*

#### *Presentation*

1. How do **clinicians and senior leaders** at Community Health Network of San Francisco address the:

- a. Effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative, and end-of-life care?
- b. Impact of poverty and socioeconomic status, race and racism, ethnicity, and socio-cultural factors on access to care, utilization, quality of care, and health outcomes?
- c. Differences in the clinical management of preventable and chronic diseases and conditions, as indicated by differences in the race or ethnicity of patients?
- d. Effects of cultural differences between patients and staff?

2. How do **clinicians** at Community Health Network of San Francisco:

- e. Provide an environment in which patients from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices **in the context of negotiating treatment options?**
- f. Encourage patients to express their health beliefs and cultural practices and, where appropriate, **integrate those approaches into treatment plans?**

3. What were the costs involved in developing and implementing these activities at Community Health Network of San Francisco? What organizational barriers needed to be overcome and how were they addressed? What actual or perceived benefits have been seen as a result of these activities?

## *Discussion*

1. What do senior leaders at NAPH systems currently do to improve their clinicians' training and abilities in recognizing and responding to the differences in the health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacies seen across their divergent patient populations?
2. What costs and benefits have been seen as a result of implementing (or attempting to implement) these activities? How were necessary funds acquired and other barriers overcome? What hurdles were insurmountable and why?
3. How can NAPH senior leaders improve their clinicians' training and abilities in this area?



*Assessing Community Needs and Building Community Relations*

**Moderators:** Samuel L. Ross, MD, Parkland Health and Hospital System  
William Walker, MD, Contra Costa Health Services

Key Points for Presentation and Discussion

*Organizational cultural competence requires a substantive understanding of the communities served and the ability to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the organization's service area. Responsive service delivery to a community requires a collaborative process that is informed and influenced by community interests, expertise, and needs. Services designed and improved with attention to community needs and desires are more likely to be used by patients, and lead to more acceptable, responsive, efficient, and effective care.*

***Presentation***

1. What methods and information sources in the community (both formal and informal) do senior leaders at Parkland and in Contra Costa County use to retrieve and update data on the needs of the different racial and ethnic groups in their service area?
2. Specifically, how do leaders at Parkland and in Contra Costa County regularly use this information to plan for, develop, and implement services that are responsive to the cultural and linguistic needs of their service area?
3. What were the costs involved in developing and implementing these activities at Parkland and in Contra Costa County? What organizational barriers needed to be overcome and how were they addressed? What actual or perceived benefits have been seen as a result of these activities?

***Discussion***

1. What methods or sources of information do senior leaders at NAPH systems use to determine the cultural factors related to patient needs, attitudes, behaviors, health practices, and concerns about using health care services among their patient populations?

Possible methods or sources of information might include:

- Marketing, enrollment, and termination figures
- Census figures and adjustments
- Voter registration data
- School enrollment profiles
- Focus groups, interviews, surveys
- County and state health status reports
- Data from other community agencies and organizations
- Collaboration and consultation with other community-based organizations, providers, and leaders on outreach, building provider networks, providing service referrals, and enhancing public relations

- Community-member participation on hospital governing boards, community advisory committees, ad hoc advisory groups, and hospital-community meetings
2. What costs and benefits have been seen as a result of implementing (or attempting to implement) these activities? How were necessary funds acquired and how were barriers overcome? Were any barriers insurmountable and why?
  3. How can NAPH senior leaders improve their ability to obtain and update data to better understand the communities they serve, and accurately plan and implement services that respond to the cultural and linguistic needs of their service areas?

## Organizing Effective Workforce Training and Education Programs

**Moderators:** *Lynda D. Curtis*, North Brooklyn Health Network, Woodhull Medical and Mental Health Center  
*Steve Mandle*, Parkland Health & Hospital System

### Key Points for Presentation and Discussion

*Senior leaders need to ensure that workforce training and education activities provided at their organizations go beyond enabling staff to superficially address the healthcare-related cultural needs of patients. Many staff training programs in this competency area are insufficient and not very helpful in informing staff on how to respectfully seek input from patients on their culturally related health needs. Staff also sometimes perceives cultural competence to be an “extraordinary skill” as opposed to a fundamental component of doing their job well. Personnel training and evaluations at all levels should emphasize moving beyond cultural sensitivity (i.e., “I mean well”) to cultural competence (i.e., “I am doing well for the patient”), and regularly make explicit the link between organizational cultural competence, better care, and improved health outcomes.*

### *Presentation*

1. What workforce training and education programs do Woodhull and Parkland offer to their staff in cultural competence?
2. How do Woodhull and Parkland organize their workforce training and education programs to ensure that they:
  - a. Are tailored for relevance to the particular functions of the trainees and the needs of the specific populations served?
  - b. Educate staff on the effects of cultural differences between staff and patients within clinical settings?
  - c. Cover the organization’s language access policies and procedures (e.g., relevant laws and how to access interpreters and translated written materials)?
  - d. Successfully train staff on the elements of effective communication between staff and patients of different cultures and languages (e.g., how to work respectfully and effectively with interpreters and telephone language services)?
  - e. Teach staff strategies and techniques for recognizing and resolving racial, ethnic, or cultural “conflicts” with patients?
3. What were the costs involved in developing and implementing these activities at Woodhull and Parkland? What organizational barriers needed to be overcome and how were they addressed? What actual or perceived benefits have been seen as a result of these activities?

### *Discussion*

1. What workforce training and education programs in cultural competence currently exist at NAPH systems?

2. What costs and benefits have been seen as a result of implementing (or attempting to implement) these activities? How were necessary funds acquired and other barriers overcome? What hurdles were insurmountable and why?
3. How can NAPH senior leaders improve the ways in which their health systems organize their workforce training and education programs in this area?

## Improving Language Access and Interpreter Services

**Moderators:** *Loretta Saint-Louis, PhD, Cambridge Health Alliance*  
*Sherry Steinaway, Harborview Medical Center*

### Key Points for Presentation and Discussion

*Accurate and effective communication between patients and staff is the most fundamental component of the health care encounter. Language barriers frequently lead to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. Health systems are required to inform patients that they have the right to free language services and to ensure that such services are readily available. Effectively serving diverse populations requires that interpreter services be available and provided by trained and competent bilingual staff or medical interpreters, and that written materials be available and translated in a manner that accurately and appropriately conveys the meaningful substance of the document or sign being translated.*

### ***Presentation***

1. How do Cambridge Health Alliance and Harborview Medical Center organize their language access and interpreter services to:
  - a. Ensure interpreter and translated materials availability?
  - b. Assess and ensure the training and competency of individuals delivering interpreter services?
  - c. Ensure that translated materials and signs accurately convey the meaningful substance of materials written in languages other than English?
2. What were the costs involved in developing and implementing these activities at CHA and Harborview? What organizational barriers needed to be overcome and how were they addressed?
3. What actual or perceived benefits have been seen as a result of these activities?

### ***Discussion***

1. How are language access and interpreter services programs currently organized at NAPH systems across the country?
2. What costs and benefits have been seen as a result of implementing (or attempting to implement) these activities? How were necessary funds acquired and other barriers overcome? What hurdles were insurmountable and why?
3. How can NAPH senior leaders improve the ways in which their health systems organize their language access and interpreter services?

## *Developing Financial and Infrastructure Supports for Cultural Competence Initiatives*

**Moderators:**     ***John Bluford, Truman Medical Center***  
                          ***Robert A. Burton, North Broward Hospital District***

### Key Points for Presentation and Discussion

*Embedded within effectively providing culturally competent care in a health care setting are a number of prerequisite infrastructure and organizational supports. Such supports include: information systems to assess perpetually changing community demographics and gauge utilization; mechanisms to access and obtain meaningful community input on service needs; systems to effectively assess organizational capacities, strengths, and weaknesses (e.g., monitoring/evaluation tools and quality improvement mechanisms); a diverse workforce and leadership that is representative of the organization's service area; structures and procedures that support easy access to high-quality translated written materials and interpreter services; policies and procedures that provide staff with a clear and unambiguous understanding of their institution's goals and values regarding the provision of culturally competent care (and their individual role in providing such care); and the financial resources and budget allocations necessary to develop and provide these tools.*

### *Presentation*

1. What financial and infrastructure supports for cultural competence initiatives do Truman and North Broward provide for their staff and patient populations?
2. What were the costs involved in developing and implementing these supports at Truman and North Broward? What organizational barriers needed to be overcome and how were they addressed?
3. What actual or perceived benefits have been seen as a result of these activities?

### *Discussion*

1. What financial and infrastructure supports for cultural competence initiatives are currently utilized at other NAPH systems?
2. What costs and benefits have been seen as a result of developing (or attempting to develop) these supports? How was funding for these initiatives acquired and other barriers overcome? What hurdles were insurmountable and why?
3. How can NAPH senior leaders leverage their available financial and infrastructure resources to better improve the ways in which their health systems provide culturally competent care?

*How to Lead a Culturally Competent Organization*

**Moderators:** *John O'Brien, University of Massachusetts Memorial Healthcare System*  
*LaRay Brown, New York City Health and Hospitals Corporation*  
*William B. Walker, MD, Contra Costa Health Services Department*

Key Points for Presentation and Discussion

*Comments from staff at NAPH systems across the country have consistently acknowledged the singularly crucial role senior leaders play in setting the organization's tone and level of commitment to providing culturally competent care to the patient populations served. Programs and initiatives often succeed or fail solely on the basis of support from one or more senior leaders. Senior management's role in this area is to provide all staff members with the tools they need to effectively communicate and treat their diverse patient populations at the highest possible levels. These staff tools include: (1) a clear and unambiguous understanding of their institution's goals, policies, and values regarding the provision of culturally competent care; (2) training and human resources development activities that foster a "real" and comprehensive understanding of their specific service area's culturally-related, health care needs; and (3) high-quality and easily accessible interpreter and translation services. Senior leaders are also responsible for providing the infrastructure, financial, and morale-building supports necessary for staff to acquire these tools.*

*Questions for Comment and Discussion*

*Each co-moderator is asked to please address the following questions in relation to what they're doing at their individual systems (10 minutes maximum), and then lead a discussion among the general audience on that particular facet of leadership (30 minutes maximum).*

*Total session time: 2 hours (three 40-minute mini-sessions).*

***John O'Brien:*** *Organizational Values*

Given your unique, highly visible position as a CEO: specifically how and in what venues (e.g., policy and budget decisions) do you try to articulate and/or demonstrate your organization's level of commitment to cultural competence to your staff, patients, and community forcefully, consistently, and constantly?

***LaRay Brown:*** *Staff Development*

As a senior leader in the largest and one of the most diverse public hospital systems in the country: specifically how do you ensure that staff training and human resource development activities move beyond cultural sensitivity (i.e., "I mean well") to cultural competence (i.e., "I am doing well for the patient")?

**William Walker, MD:**            **Resource Allocation**

As the director of a county health department: how do you attempt to best leverage your available financial, political, and infrastructure resources to improve the ways in which your staff provides culturally competent care?

***Possible Discussion Questions/Starters for each Mini-Session***

1. As senior leaders at your organizations, how do you try to ensure that your staff is receiving all the tools they need in this particular area of providing culturally competent care?
2. What were the costs involved in developing and conducting these activities? What organizational barriers needed to be overcome and how were they addressed? How was funding for these initiatives acquired and other barriers overcome? What hurdles were insurmountable and why?
3. What actual or perceived benefits have been seen as a result of these activities?
4. How can NAPH senior leaders continue to better improve the ways in which their health systems provide culturally competent care?