Best Practices for Improving Cultural Competency in the Health Care Workforce

May 24, 2013

Dial 888-437-3195 for the webinar audio
Overview

• Introduction

• Why cultural competency?
  ➢ The Oregon Approach

• Culturally Competent Health Care, Legislative Initiatives, CLAS Standards

• Best Practices for States to Consider
Presenters

• **Representative Alissa Keny-Guyer**, Vice Chair
  Oregon House Committee on Health Care

• **Tricia Tillman**, Director
  Oregon Health Authority, Office of Equity and Inclusion

• **Dr. Robert Like, M.D., M.S.**, Professor & Director
  Center for Healthy Families and Cultural Diversity,
  Department of Family Medicine and Community Health,
  UMDNJ-Robert Wood Johnson Medical School
Presentation Objectives

1. Provide a history of efforts leading up to the passage of Cultural Competency CE
2. Provide an overview of HB 2611
3. Provide a brief overview of 2 complementary health equity bills
4. Share next steps for advancing cultural competence in Oregon’s health systems
Vision

All people, communities and cultures co-creating and enjoying a healthy Oregon.

Mission Statement

To engage and align diverse community voices and the Oregon Health Authority to assure the elimination of avoidable health gaps and promote optimal health in Oregon.
Community identifies CC as priority 1999, 2008, 2010
Governor’s Racial and Ethnic Health Task Force

Final Report

Submitted to:
Governor John A. Kitzhaber,

November 2000

Health Equities Committee Recommendations

Report to the Oregon Health Fund Board
Communities of Color Policy Forums February and April 2010

Policy Priorities:

• Equal access to health care regardless of documentation status or disability
• Culturally sensitive/competent health care systems
• Diverse and culturally competent health care providers
Table of contents

An urgent call to action
Oregon’s solutions
OHPB committees

Foundational strategies in brief
- Strategy #1 – Use purchasing power to change how we deliver a
- Strategy #2 – Shift focus to prevention
- **Strategy #3 – Improve health equity**
- Strategy #4 – Establish a health insurance exchange to make it easy for Oregonians to get affordable health insurance
- Strategy #5 – Reduce barriers to health care
- Strategy #6 – Set standards for safe and effective care
- Strategy #7 – Involve everyone in health system improvements
- Strategy #8 – Measure progress

Key actions

What will be different after Oregon’s Action Plan for Health
Taking advantage of federal reform opportunities for real
Establishing the vision
Cultural Competence CE Legislative Timeline

Community identifies CC as priority

2010 Draft CC CE legislation
2010 - Legislative Concept

• Shared the concept with
  – Health licensing boards
  – Health professional associations
  – Community based organizations
  – Advocacy organizations
  – Health systems

• Presented with community partners and health professionals
  – Board of Nursing
  – Health Licensing Directors
Cultural Competence CE Legislative Timeline

- 1999, 2008, 2010: Community identifies CC as priority
- 2010: Draft CC CE legislation
- 2011: SB 97; HB 3650 Health Systems Transformation
Organizations endorsing cultural competence continuing education, 2011
Cultural Competency is essential to eliminating health disparities and achieving the Triple Aim.

Recommendations for Advancing Cultural Competency

- Oregon’s Action Plan for Health
- OEI Community Policy Forums
- CCO Requirements
- OHPB Workforce Committee
Cultural Competence CE Legislative Timeline

Community identifies CC as priority

2010 Draft CC CE legislation

2011
SB 97; HB 3650 Health Systems Transformation

2012
Cultural Competence Continuing Ed. Committee
Cultural Competency Continuing Education Committee

Diverse Committee Membership:
• Cultural and Social Diversity
• Curriculum Developers
• Community Based Organizations
• Academics
• Small Business
• Licensing Boards
• Professional Associations
• Health Care Providers

Definitions and Standards
- Develop definitions and standards for cultural competency
- Survey to glean feedback on proposed definition and standards from over 160 health professionals

Explore Existing CE Options
- Scan existing CE options to identify currently available trainings by cost, provider type, population, etc
- Review these trainings with proposed standards to ensure they meet needs.

Explore Operational Issues
- Survey licensing boards to identify feasibility of implementing cultural competency and to better understand operational issues for implementation
- Develop recommendations for advancing cultural competency in conjunction that meet licensing board concerns
Cultural Competency Definition

- Examining values and beliefs
- Developing and applying an inclusive approach to healthcare practice
- Recognizing the context and complexities of provider-patient interactions
- Preserves the dignity of individuals, families, and communities

Cultural Competency Standards

- Culturally Competent practice requires self-awareness and self-assessment of beliefs, attitudes, emotions and values.

- Culturally Competent practice requires the acquisition of knowledge by providers.

- Culturally Competent training requires specific educational approaches for knowledge acquisition.

- Culturally competent practice requires the acquisition of skills.
2013 Committee Recommendations

• Licensing Boards
  – If interested, implement mandate for licensee cultural competency training
  – If unable to implement mandate, implement voluntary process and track progress of licensees

• Oregon Health Authority
  – Require training for all staff, contractors and subcontractors
  – Leverage funds to support implementation of CCCE for licensing boards
  – Develop website with training registry
  – Convene a new committee to advance organizational approaches

• Coordinated Care Organizations
  – Require training for all staff

• Curriculum Developers
  – Update curriculum to meet proposed CC standards
Cultural Competence CE Legislative Timeline

1999, 2010 Community identifies CC as priority

2010 Draft CC CE legislation

2011 SB 97; HB 3650 Health Systems Transformation

2012 Cultural Competence Continuing Ed. Committee

2013 HB 2611
Representative Keny-Guyer re-introduces cultural competency bill for Urban League of Portland and Oregon Health Equity Alliance

- Used recommendations from Cultural Competence Continuing Education Committee
- Engaged with new and established legislative champions
- Engaged stakeholders to negotiate effective compromise
  - Voluntary continuing education for licensees
  - Licensing boards required to report and track
2013 Legislative Session: HB 2611

- **Key components of HB 2611**
  - Licensing boards
    - may make Cultural Competence CE a requirement of licensure
    - Shall document participation in Cultural Competence CE
    - Shall report biennially to the Oregon Health Authority
    - May use fees to implement the act
  - Oregon Universities
    - May require health professionals to take Cultural Competence CE
  - Oregon Health Authority
    - Shall report biennially to the Legislature
    - Shall identify and approve Cultural Competence CE
    - May receive and grant funds to support this work
2013 Legislative Session: HB 2611

• Key Stakeholders:
  • Oregon Health Equity Alliance
    – Asian Pacific American Network of Oregon
    – Causa
    – Center for Intercultural Organizing
    – Oregon Action
    – Oregon Latino Health Coalition
    – Urban League
  • Oregon Nurses Association
  • Oregon Medical Association
  • Oregon Health Care Association
  • Oregon Primary Care Association
  • Oregon Advocacy Commissions
  • Oregon Student Association
  • Oregon University Systems
  • SEIU
2013 Legislative Session: HB 2611

First reading. Referred to House Speaker's desk
Referred to Health Care
Recommendation: Do pass with amendments and be printed A-Engrossed

Third reading. Carried by Keny-Guyer (D). Passed. Ayes, 46; Nays, 12

First reading. Referred to Senate President's desk
Referred to Health Care and Human Services
Recommendation: Do pass A-Engrossed Bill
Third reading. Carried by Sen. Winters (R). Passed. Ayes, 26; Nays, 2
Other Health Equity Legislation

HB 2134
• Would establish uniform standards for collection of data on race, ethnicity, preferred languages and disability status in surveys and in all programs in which authority or department collects, records or reports such data

• Third reading. Carried by Keny-Guyer. Passed House. Ayes, 55; Nays, 4
• Third reading. Carried by Monnes Anderson. Passed Senate Ayes, 28; Nays, 0
Other Health Equity Legislation

HB 3407

- Establishes Traditional Health Workers Commission within the Oregon Health Authority

- House Health and Human Services Committee Recommendation: Do pass with amendments, referred to Ways and Means by prior reference.
Cultural Competence CE Legislative Timeline

1999, 2010
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SB 97; HB 3650 Health Systems Transformation

2012
Cultural Competence Continuing Ed. Committee

2013
HB 2611

Beyond 2013 -> Implement committee recommendations, legislation
2013 – OEI Next Steps

• Implementation of CC CE Committee rec’s
  – Work with CCOs and Innovator Agents
  – Convene and sustain CC CE committee
    • Identify, assess, approve CC CE options
    • Support for curriculum developers
    • Committee focused on Organizational CC
  – Work with Health Licensing Boards
    • definitions
    • CE infrastructure
  – CC CE requirements for OHA staff
Next Steps for Advancing CC beyond HB 2611

Cultural Competency Strategies

Oregon Health Reform
- Health Professionals Training
- Organizational Structure
- Non-Traditional Health Workers
- Race Ethnicity and Data Language Collection
- DELTA

Community Engagement
- State of Equity Report Community Conversations
- Regional Equity Coalitions
- Community Based Organization’s Legislative Advocacy
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http://www.oregon.gov/OHA/oei/
Best Practices for Improving Cultural Competency in the Health Care Workforce: Lessons Learned and Future Opportunities

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Objectives

• Define the concept and rationale for culturally competent health care

• Identify state legislation and accreditation standards requiring education about health disparities and culturally competent care

• Share selected state initiatives, including the author’s experience in New Jersey providing cultural competency training

• Introduce the OMH Enhanced National CLAS Standards and their importance for health care reform efforts

• Discuss examples of selected legislative policy options, actions, and best practices that can help support the education of a culturally competent health professions workforce and facilitate culturally and linguistically appropriate service delivery.
Defining Cultural Competence

“The ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients’ social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, [language proficiency, literacy, age, gender, sexual orientation, disability, religion, or socioeconomic status].”

Adapted and expanded from the Commonwealth Fund. New York, NY, 2002 - www.cmwf.org
Rationale for Culturally Competent Health Care

- Responding to demographic changes
- Eliminating disparities in the health status of people of diverse racial, ethnic, & cultural backgrounds
- Improving the quality of services & outcomes
- Meeting legislative, regulatory, & accreditation mandates
- Gaining a competitive edge in the marketplace
- Decreasing the likelihood of liability/malpractice claims


“Healthcare providers should be made aware of racial and ethnic disparities in healthcare .... In addition, all current and future healthcare providers can benefit from cross-cultural education.”

How Far Have We Come in Reducing Health Disparities?: Progress Since 2000 - Workshop Summary, 2012
Agency for Healthcare Research and Quality

National Health Care Disparities and Quality Reports, 2003-2011

- Health care quality and access are suboptimal, especially for minority and low income groups.
- Quality is improving; access and disparities are not improving.
- Urgent attention is warranted to ensure continued improvements in quality and progress on reducing disparities with respect to certain services, geographic areas, and populations.
- Progress is uneven with respect to national priorities identified in the National Quality Strategy and Disparities Action Plan.

http://nhqrnet.ahrq.gov/nhqrdr/jsp/nhqrdr.jsp#snhere#snhere
The Economic Burden of Health Disparities

Between 2003 and 2006 ….

- The combined costs of health inequalities and premature death in the United States were $1.24 trillion.
- Eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion.
- **30.6% of direct medical care expenditures** for African Americans, Asians, and Hispanics were excess costs due to health inequalities.
- Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by **more than one trillion dollars**.


http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf
HHS Action Plan to Reduce Racial and Ethnic Health Disparities, April 2011

National Stakeholder Strategy for Achieving Health Equity, April 2011
http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286
National Call to Action to Eliminate Health Care Disparities
www.equityofcare.org

Equity of Care

✓ Increasing the collection and use of race, ethnicity and language preference data
✓ Increasing cultural competency training
✓ Increasing diversity in leadership

Participating organizations include:

AAMC
American College of Healthcare Executives
American Hospital Association
CHA
Catholic Health Association of the United States

Racial and ethnic minorities currently represent one-third of the U.S. populations. -U.S. Census Bureau
The Commission to End Health Care Disparities
www.ama-assn.org/go/healthdisparities

Quality care for all people

Commission Secretariat
American Medical Association
National Medical Association
National Hispanic Medical Association
Legislative Initiatives to Foster Health Equity and Cultural Competency

Patient Protection and Affordable Care Act of 2010: Advancing health equity for racially and ethnically diverse populations

State-level strategies to address health and mental health disparities through cultural and linguistic competency training and licensure: an environmental scan of factors related to legislative and regulatory actions in states

Legislation as intervention: A survey of cultural competence policy in health care
Standards, Accreditation Requirements, and Guidelines

- DHHS Office of Minority Health - National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
- Joint Commission
- National Committee for Quality Assurance
- National Quality Forum
- Liaison Committee on Medical Education
- Accreditation Council for Graduate Medical Education
Health Care Workforce: The Need for Interprofessional Training

Nursing ↔ Medicine ↔ Behav Health

Oral Health ↔ CULTURAL COMPETENCE EDUCATION ↔ Pharmacy

Allied Health ↔ Public Health ↔ Social Work
Evidence Base for Cultural Competency Training

There is some evidence that interventions to improve quality of healthcare for minorities, including cultural competence training, are effective.

Name of AAFP-approved source: AHRQ


Strength of evidence:
A systematic review of 91 articles, of which 64 were chosen that evaluated cultural competence training as a strategy to improve the quality of healthcare in minority populations. There is excellent evidence for improvement in provider knowledge, good evidence for improvement in provider attitudes and skills, and good evidence for improvement in patient satisfaction.
State Initiatives: Best and Promising Practices

AHCPR User Liaison Program: Providing Care to Diverse Populations: State Strategies for Promoting Cultural Competency in Health Systems
Workshop Summary, June 9-11, 1999

• **Dark Blue** denotes legislation requiring (NJ, CA, WA, NM, CT) or strongly recommending (MD) cultural competence training, which was signed into law.

• **Burgundy** denotes legislation (NY, OH, AZ, KY, GA) which has been referred to committee and is currently under consideration.

• **Dark Yellow** denotes legislation (IL, FL, IA, OR) which died in committee or was vetoed (CO).

Adapted from https://www.thinkculturalhealth.hhs.gov/Content/LegislatingCLAS.asp
New Jersey – 2005
Cultural Competency Legislation

- Law enacted requiring NJ Board of Medical Examiners in consultation with Commission on Higher Education to prescribe requirements, by regulation, for physician [and podiatry] training in cultural competency (See N.J.S.A. 45:9-7.2 and 7.3).

- Legislation requires that all medical schools in NJ provide instruction to their current and future students in cultural competency. This instruction is required as a condition of receiving a diploma from a college of medicine in NJ.

- NJ medical schools are also required to provide cultural competency CME instruction for licensed physicians [6 CME credits] who were not required to and did not receive cultural competency training in their medical school curriculum.

Majority Opted for Online Programs

Selected Cultural Competency Distance Learning Programs

Free
Office of Minority Health
*A Physician’s Practical Guide to Culturally Competent Care*
https://cccm.thinkculturalhealth.org

Health Resources and Services Administration
Effective Communication Tools for Health Professionals
(formerly Unified Health Communication 101)
http://www.hrsa.gov/publichealth/healthliteracy

Private Sector Programs
Cultural Competency Live CME Program

“Improving the Quality of Care Provided to New Jersey’s Diverse Communities”

Educational Modules

• Health Disparities, Cultural Competency, and Implications for Quality Care
• Caring for Diverse Populations: Understanding Your Communities
• Culturally Competent Patient-Centered Care
• Caring for Patients with Limited English Proficiency
• Addressing Cross-Cultural Health Literacy Challenges in Clinical Practice
• Becoming a Culturally Competent Medical Practice
Qualitative Results

Selected Participant Reactions – “The Good, Bad, and Ugly”

• Opposition to mandated training requirements
• Anger toward subject area and waste of time
• Frustration with health care system, inadequate reimbursement, and liability issues
• Already knew this from experience/more appropriate for medical students
• Pleasantly surprised
• Relevant and useful
• Felt other topics needed to be covered

http://www.diversityrx.org/blog/your-voices/%E2%80%9Cgood-bad-and-ugly%E2%80%9D-cultural-competency-training-how-should-we-respond-feedback
The Maryland Health Improvement and Disparities Reduction Act of 2012

Provisions

1. Establish Health Enterprise Zones (HEZ) in small geographic areas having very poor health statistics, health disparities and high poverty. The HEZ is eligible for loan repayment assistance, tax credits, capital equipment credits, electronic medical records assistance and participation in the Patient Centered Medical Home program, and funding for four years.

2. Establish and incorporate a standard set of measures regarding racial and ethnic variations in the State Quality Outcomes reports generated by the Maryland Health Care Commission. Include information on the actions taken by carriers to track and reduce health disparities, including whether the health benefit plan provides culturally appropriate educational materials for its members.

3. Require each non-profit hospital in the State to include in their Annual Community Benefits Reports, a description of the hospital's efforts to track and reduce health disparities.

The Maryland Health Improvement and Disparities Reduction Act of 2012

Provisions

4. Require institutions that offer programs necessary for the licensing of health care professionals in the State to report on their actions taken to reduce health disparities.

5. Two state commissions that work with hospital and health insurer data, shall recommend standards for evaluating the impact of the Maryland Patient Centered Medical Homes on eliminating health disparities.

6. Form a workgroup to develop standards and criteria for cultural competency in medical and behavioral health treatment settings.

http://dx.confex.com/dx/13/webprogram/Paper3516.html
Cultural Competency Training: Lessons Learned

- Need to create learning environments that foster safety, trust, and respect
- Within-group diversity is often greater than between-group diversity
- There is no “cookbook approach” to treating patients
- Avoid stereotyping and overgeneralization and address the “isms”
- An assets and strengths-based perspective is important to maintain
- Remember that every encounter is a cross-cultural encounter
- Developing cultural competency is a life-long journey and not a final destination
Becoming a Culturally Competent Health Care Organization and Service Delivery System
OMH - Think Cultural Health: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

• Advances health equity, improves quality, and helps to eliminate health care disparities by providing a blueprint to implement culturally and linguistically appropriate services

• In 2010 Office of Minority Health launched the National CLAS Standards Enhancement Initiative to revise the standards, expand their scope, and improve their clarity to ensure understanding and implementation

https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
OMH - National CLAS Standards

1. Principal Standard

2-4. Governance, Leadership and Workforce

5-8. Communication and Language Assistance

9-15. Engagement, Continuous Improvement, and Accountability

What’s New in the National CLAS Standards?

Enhanced implementation guidance: *The Blueprint*

“Exchanges should consider recommending that health plans qualified to be sold in the exchange use resources such as the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) to guide effective implementation, especially for racially and ethnically diverse consumers.”

“Navigators, in-person assisters, call center personnel, and others who deal with consumers should receive adequate training in cultural and linguistic competency standards, and translators and interpreters should be trained and follow professional standards.”
What Can State Legislatures Do?

• Serve as community leaders/champions in developing initiatives to raise awareness about disparities in health and health care, and empower change that meets the Triple Aim of better health (*population health*), better care (*experience of care*), and lower cost (*per capita cost*).

• Craft legislation and policies that are culturally and linguistically competent and consider the impact on diverse communities and constituencies.

• Facilitate efforts to eliminate disparities in access, service utilization, quality and outcomes that exist in different populations (e.g., Medicaid).

• Insure that the State Employee workforce receives high quality culturally and linguistically appropriate care.
What Can State Legislatures Do?, cont.

- Support efforts to integrate cultural and linguistic competence into patient-centered medical homes, integrated primary care/behavioral health homes, accountable care organizations, and other emerging service delivery models
- Convene study groups, blue ribbon panels, task forces, and other advisory groups, and hold town hall meetings and hearings to solicit input and participation from community members
- Incentivize the integration of life-long cultural and linguistic competency education into K-12, undergraduate, postgraduate, and professional training and evaluate its effectiveness and outcomes
- Avail themselves of opportunities to participate in ongoing cultural competency training.
Key Messages

• Disparities in health and health care are common and disproportionately impact minority, ethnic, and socio-economically disadvantaged communities.

• Recent health care policy, legislative, accreditation, and professional initiatives emphasize the importance of addressing disparities and providing culturally and linguistically appropriate services (CLAS) to our diverse population.
Key Messages

• Educating leadership and the health care workforce about the provision of high quality, patient-centered, culturally responsive and effective care is critically needed to help reduce disparities and foster health equity.

• Cultural competency training is necessary but not sufficient to eliminate disparities.
A Personal Perspective

Developing Cultural Competency – A Transpartisan Issue?

Cultivating Cultural Humility – Seeing the Humanity in Us All!

- A lifelong commitment to self-evaluation and self-critique
- Redressing power imbalances
- Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations


Diversity in America: A Meditation

What is your preferred image?

- Rainbow
- Kaleidoscope
- Mosaic
- Salad
- Melting Pot
- Cauldron
- Other?
“Adding wings to caterpillars does not create butterflies -- it creates awkward and dysfunctional caterpillars. Butterflies are created through transformation.”

Stephanie Pace Marshall

Questions?

Webinar archive will be available online next week

www.ncsl.org

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