**10th Conference on Health Care of the Chinese in North America**

**What is Cultural Competency: A National Mantra**

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What is cultural competency? It has become a national mantra as the U.S. attempts to address its multinational mix. The National Public Health and Hospital Institute defines cultural competency as "incorporating the ethnic/cultural characteristics of individuals and their communities in addressing their health care needs and in promoting health."

In 1990, when the San Francisco Department of Public Health established a program for cultural specialists it defined the terms as:

"The word **culture** is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial ethnic, religious or social group. The word **competence** is used because it implies having the capacity to function within the context of culturally integrated patterns of human behavior as defined by the group."

The Office of Minority Health (OMH) releasing fourteen draft standards for culturally and linguistically appropriate services (CLAS) wrote "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and polices that come together in a system, agency, or among professionals that enables effective work in cross cultural situations. **Culture** refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. **Competence** implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."

In today's multicultural society, physicians and patients must be able to communicate. A patient must be able to communicate his or her needs, the physician needs to be able to understand what the patient is communicating. This often include understanding the socioeconomic and cultural background of the patient, including his or her health beliefs. The physician also needs to understand the different types of illness that may occur due to his or her background and immigrant status. For example, when caring for a Chinese patient, the physician needs to be aware of certain illnesses not commonly seen in the United States such as thalassemia, stomach cancer, hepatoma and nasopharyngeal carcinoma. The physician also needs to be aware of certain common problems of immigrants from Southeast Asia, such as tuberculosis, parasites, etc. Further, the physician also needs to be aware what to expect, in succeeding generations such as the increasing risk of cardiac disease or breast cancer.

In 1999, the President issued an Executive Order calling for a White House initiative on the

health status of Asian Americans and Pacific Islanders including the creation of a Presidential Commission charged with making recommendations to the President.

As part of the government's initiative to improve access for minorities, the Office of Minority Health released 14 draft standards for culturally and linguistically appropriate services (CLAS) (See Appendix 1). OMH wrote, "More and more providers are treating a diverse group of patients, and culturally competent care improves health outcomes and patient satisfaction." While the standards would create a floor for patient interaction with health care providers, they do not address the core competencies for delivery of services.

The key elements for CLAS are Access, Availability, Acceptibility, and Affordability. In our community, we also need to address the bimodal distribution of the population: a low income, poorly educated, mostly immigrant population more comfortable using their native language, and a high income, well educated, mostly assimilated population.

In any program, we need to understand the target population. For our community there have been a few studies concerning development of programs reaching out particularly to the low income and needy monolingual population, including the Association of Asian Pacific Community Health Organizations (AAPCHO) study, the National Public Health and Hospital Institute and others. In 1996, Miguel Tirado, PhD, from the Latino Coalition for a Healthy California, and the CCHCA collaborated on a study that revealed the different ways Chinese and Hispanic practitioners approached common medical problems. The San Francisco Department of Public Health is using the fourteen draft standards as the basis of evaluating cultural competency in its contractors. This started about a year ago, and is in collaboration with the contractors. A report should be due to the Health Commission sometime this year on its applicability.

We also need to measure patient satisfaction in a different manner than is prevalent in the United States. The deference to authority and traditional modesty makes resource instruments unreliable. The Agency for Healthcare Research and Quality in noted Asian patients were least satisfied with their services. AHRQ noted that the findings might represent actual differences in quality of care, or a variation in patient perception and expectations or a questionnaire response style. It is an important alert for more research into the subject of patient ratings in the Asian population.

Certainly, our work at this conference should be to see that access, availability, acceptability, and affordability are available to all. However, the greater emphasis is on those who have not become assimilated. This is not to minimize the need to also reach out to those who are assimilated. There are diseases that are low in prevalence in the home country that become important in the new generations in America such as increasing heart disease and breast cancer among Chinese. Our colleagues preceding us in this same panel session have illustrated this in their work on atherosclerosis in sites in China and San Francisco.

I look forward to the dialog that will occur on our panel which will include an expert on cultural competent services who has written a most important text on the subject, the practical application in a large urban county in California, and the special needs of Asians with HIV disease.

Dr. Chow is Medical Director of the Chinese Community Health Plan, the only health maintenance organization owned and operated by its Chinese community in the United States, and Executive Director of the Chinese Community Health Care Association, a 140 member non profit mutual benefit association. He has been for 10 years a Commissioner of the San Francisco Health Commission, serving as its President, Vice President, and Budget Chair at different times. He was a charter member of the Multicultural Task Force to the California Director of Health in 1993-1997.

Preamble:

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment. Commentary

Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation. Commentary

Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning. Commentary

Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served. Commentary

Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery. Commentary

Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services. Commentary

Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services. Commentary

Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas. Commentary

Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both

languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities. Commentary

Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff. Commentary

Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community. Commentary

Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs. Commentary

Develop structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services. Commentary

Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources. Commentary

1999, HHS Office of Minority Health and Resources for Cross Cultural Health Care

From January 1-April 30, 2000, you may submit your official comments on the standards. We recommend you review the full report and individual commentaries on each standard before writing your comments.