Addressing Cultural and Linguistic Competence In the HCH Setting: A Brief Guide

Introduction

Although there is no universally accepted definition of cultural and linguistic competency, a useful definition adopted by the Office of Minority Health (OMH) distinguishes between culture, competence and the relationship between the terms:

- "**Cultural and linguistic competence** is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among health professionals that enables 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." [i]

Although many people think that culture refers only to knowledge, attitudes, beliefs, and behaviors influenced by race or ethnicity, the concept also includes factors such as age, gender, socioeconomic status, level of education, physical capacity, spirituality and religion, sexual orientation, and regional influences.

This broad definition takes into account what Health Care for the Homeless (HCH) providers strive to do on a daily basis: skillfully deal with the individual concerns presented by each client.

HCH providers are sensitive to their client's attitudes, beliefs, and behaviors, many of which are shaped by their direct experience of poverty and homelessness. For instance, it is not uncommon for people experiencing homelessness to be concerned about privacy issues, fearful or untrusting of larger institutions and the people to work in them, and embarrassed about their difficulty maintaining personal hygiene.

These concerns are often compounded by negative interactions with family, friends, health care providers, police, and the community at large. As a result, displaced people may behave in ways that often appear resistant, complacent, bizarre, or disruptive to the untrained eye.

The growing number of homeless clients from diverse racial, ethnic and cultural backgrounds, often with limited English proficiency, demonstrates the need for culturally and linguistically competent services.

This document provides a framework for understanding the basic requirements of culturally and linguistically competent health care delivery and identifies key resources with which HCH projects and other health care providers should be familiar.

What is the rationale for delivering culturally competent and linguistically appropriate health care services?

As the U.S. population becomes more diverse, the need for the delivery of culturally competent and linguistically appropriate health care services is paramount. By 2010, Hispanics/Latinos will be the largest minority group in the United States, comprising nearly 20% of the population. [ii]

Persuasive arguments to support the provision of culturally competent and linguistically appropriate care include: "improving the quality of services and outcomes; meeting legislative, regulatory, and accreditation mandates; ... and decreasing the likelihood of liability/malpractice claims". [iii]

The most compelling reason is the poor health status and unfavorable outcomes of racial and ethnic minorities in comparison with the general U.S. population. A recent National Academies Institute of Medicine reports the persistence of racial and ethnic health disparities even after adjustment for income and health insurance status. [iv]

Examples of just a few of these health disparities include:

- **Cardiovascular Disease**: Studies indicate that minorities are less likely to be given appropriate cardiac medicines or to undergo bypass surgery.
- **Cancer**: Studies indicate that there are racial differences in who receives appropriate diagnostic tests and treatments.
- **HIV/AIDS**: Minorities with HIV infection are less likely to receive antiretroviral therapies.
- **Diabetes**: Minorities have a higher rate of illness and death from diabetes.
- **Maternal and Child Health**: Minority women are more likely to undergo cesarean deliveries and minority children are less likely to receive prescription medications.

Nationally, health care organizations and programs are struggling to respond effectively to the health care needs of racially, ethnically, culturally and linguistically diverse clients. Health Care for the Homeless projects are no exception.

What do we know about the racial, ethnic, and linguistic diversity among HCH clients?

According to a 1996 Urban Institute analysis, homeless clients are disproportionately Black non-Hispanic, Hispanic, and Native American compared to the total U.S. adult population.

Race / Ethnicity of Homeless Clients and U.S. Adults

Race/Ethnicity	Homeless Clients	U.S. Adult Population (1996)
White non-Hispanic	**41%**	76%
Black non-Hispanic	**40%**	11%
Hispanic	**11%**	9%
Native American	**8%**	1%
Other	**1%**	3%

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Race/ethnicity information for the U.S. adult population calculated from Bureau of the Census (1997a), table 23. Cited from *Homelessness: Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients*, Interagency Council on the Homeless, December, 1999.

National summary data from the 2004 Uniform Data System (UDS) indicates that the majority of clients served by HCH projects belong to racial/ethnic groups other than White non-Hispanic. Among adults receiving HCH services, the two largest identified racial/ethnic groups are Black/African American (34.7%) and Hispanic/Latino (20.1%) Over 15 percent are identified as clients best served by languages other than English.

Proportion of Users by Race/Ethnicity/Language Health Care for the Homeless		
Race/Ethnicity/ Language	**Number**	**Percent**
1. Asian/Pacific Islander	11,643	**2.0**
2. Black/African American	203,992	**37.4**
3. American Indian/Alaska Native	8,145	**1.4**
4. White	208,160	**35.4**
5. Hispanic or Latino	118,125	**20.1**
6. Unreported/Unknown	38,230	**6.5**
Total Users (sum of lines 1-6)	588,295	**100.0**
Users best served by languages other than English (including Sign Language)	89,024	**15.1**
Source: Table 3B –modified: Uniform Data System, Bureau of Primary Health Care, 2004		

What are current federal requirements for recipients of Federal Funds?

In 2001, the U.S. Department of Health and Human Services' Office of Minority Health (OMH) published National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). Based on Title VI of the Civil Rights Act of 1964, the document identifies the current Federal requirements for all recipients of Federal Funds (CLAS Standards 4, 5, 6, 7). For complete information on compliance with these mandates, consult the HHS Guidance on Title VI at http://www.hhs.gov/ocr/lep.

- **Standard 4.** "Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."
- **Standard 5.** "Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services."
- **Standard 6.** "Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)."
- **Standard 7.** "Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area." [v]

In addition, OMH recommends additional guidelines for adoption as mandates by Federal, State and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13) and for voluntary adoption by health care organizations (Standard 14). For complete details about the CLAS standards, consult the Final Report on National Standards for Culturally and Linguistically Appropriate Services in Health Care at http://www.nhmamd.org/pdf/CLASfinalreport.pdf.

What are culturally competent and linguistically appropriate services?

The task of identifying appropriate tools in order to deliver culturally competent and linguistically appropriate services is difficult and time-consuming. As previously mentioned, there is no universally accepted definition of the term, nor are there clear guidelines as to what criteria makes an individual health professional or health organization culturally competent.

Second, although there is a plethora of information relating to cultural competency at the individual and organizational level, it is impossible to determine the effectiveness of any approach simply because there has been little or no validating research to demonstrate the effectiveness of one approach over another. As a result, individual health care professionals and organizations seeking to overcome cultural and linguistic barriers to care have adopted a wide variety and/or combination of approaches including:

- Provision of staff training, sometimes referred to as cultural sensitivity or diversity training
- Utilization of bilingual providers

- Utilization of bilingual family members and support staff
- Utilization of professional medical interpreters
- Utilization of telephonic interpretation services

All of these methods have pros and cons, but some have serious implications that HCH projects should approach with caution.

What approaches should be avoided?

The 1999 Multicultural Health Best Practices report prepared by the Resources for Cross Cultural Health Care describes a variety of commonly used approaches that may in fact jeopardize the health of limited English-speaking (LEP) clients.

- **No Interpreter:** Although this approach is still quite common, trying to provide health care without language assistance may lead to poor quality of care such as misdiagnosis and may constitute a violation of the patient's civil rights.
- **Chance Interpreters:** Family members or friends are often poor interpreters. They routinely edit, add, change the message and often end up controlling the interaction between the patient and provider.
- **Bilingual Support Staff:** Untrained and unscreened bilingual support staff often make the same types of errors as chance interpreters. Problems can be reduced by setting up a formal system of using bilingual staff services, screening the language skills and providing them with interpreter training.
- **Bilingual Providers:** Utilization of bilingual providers whose language proficiency has not been ascertained or providers who have taken "crash courses" in "medical Spanish" may in fact have adequate language proficiency to build rapport with clients but inadequate language skills to provide appropriate diagnosis and treatment services.

What approaches are applicable to HCH Settings?

Sections of the report that may be applicable to HCH settings include the following training recommendations to address cultural and linguistic barriers to care:

- **Bilingual Support Staff Training:** Consider setting up a formal system of using bilingual staff services including language skills screening and provision of interpreter training. Topics addressed in interpreter training might include medical terminology, code of ethics, and the role of the interpreter.
- **Provider Training:** For providers who are not bilingual or have less than adequate language skills for diagnosis and treatment, training on how to best utilize a professional interpreter or bilingual staff person may improve the actual communication between the provider and client. In addition, it may ameliorate some of the role confusion between the provider and interpreter. Additional training, using discussion and problem-solving methodologies, could also serve to improve the cultural competency of providers.
- **Organizational Cultural Competency:** In general, it is easier to develop organizational policies and programs for specific ethnic groups or special populations than it is to develop and implement organizational cultural competence. Organizations that claim to provide culturally competent services to specific ethnic groups or special populations may in fact be unfriendly to diversity. It is often more challenging to achieve multiethnic cultural competence. True cultural competence requires the commitment, attention and resources from the top management of the organization. For specific guidelines that may assist you in the development of organizational policies, consult the National Standards for Culturally and Linguistically Appropriate Services in Health Care developed by the Office of Minority Health at http://www.nhmamd.org/pdf/CLASfinalreport.pdf.

Availability of Training and On-Site Technical Assistance

HRSA grantees, including HCH projects, are eligible to co-sponsor cultural competency workshops and/or request on-site technical assistance from HRSA's Managed Care Technical Assistance Center (MCTAC). MCTAC training sessions include:

- Introduction to Cultural Competence: A Practical Approach to Developing & Implementing Culturally Competent Health Care Organizations and Services
- A Practical Guide to Providing Culturally and Linguistically Appropriate Health Care Services
- A Practical Guide to Culturally and Linguistically Appropriate Health Care Organizations
- Integrating Cultural Competence into Clinical Care

For more information about the workshops, role of workshop co-sponsors, and on-site technical assistance, please call the Managed Care Technical Assistance Center toll-free at 1-877-832-8635 or e-mail at **hrsa_mctac@jsi.com**.

Useful Websites

The following websites provide information on cultural competency and interpreter training, ethnic community profiles, books, articles, videos, newsletters, Spanish language patient education materials, models of organizational competence, and information about current research projects and federal initiatives.

Web Site:	Description
Diversity RX http://www.diversityrx.org/	This website provides facts about language and cultural diversity in the United States; offers an overview of models and strategies for overcoming cultural and linguistic barriers to health care; reviews federal, state and organizational polices and protocols; addresses legal issues; addresses research that has been performed in this area; and provides networking and resources. In addition, they sponsor conferences and offer training packages.
The Cross Cultural Health Care Program, Seattle WA http://www.xculture.org/	Provides relevant information in the form of books and resources, training programs, interpreter services, translation services, and research programs.
The Center for Cross Cultural Health, Minneapolis, MN http://www.crosshealth.com/	Offers conferences, training, publications and additional links to other related websites.
National Center for Cultural Competence, Georgetown University Child Development Center http://gucdc.georgetown.edu/	Provides publications, a newsletter, policy briefs and additional links to related websites that are designed to assist in the design, implementation and evaluation of culturally competent service delivery systems.
The National MultiCultural Institute http://www.nmci.org/	Provides information on organizational training and consulting, conferences, publications and resource materials including trainer manuals, books on cross-cultural mental health and videos.
The Provider's Guide to Quality and Culture http://erc.msh.org/	Provides an interactive quality and culture quiz; topics on quality and culture such as clinical outcomes, common health problems in selected minority, ethnic and cultural groups, common beliefs and cultural practices, relating to patient's families, culturally competent organizations; working with an interpreter; book excerpts and additional resources.

Web Site:	Description
EthnoMed, Harborview Medical Center, Seattle WA http://www.ethnomed.org/	Information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants, many of whom are refugees fleeing war-torn parts of the world. This site contains profiles of a variety of ethnic groups, including Hispanics/Latinos as well as patient education materials in a variety of languages.
Center for Linguistic and Cultural Competence in Health Care http://www.omhrc.gov/cultural	The Office of Minority Health (OMH) oversees the Center for Linguistic and Cultural Competence in Health Care website, which was developed as resource to address the needs of limited English-speaking patients. This website is a great resource for standards, policy initiatives, data/statistics, publications, federal clearinghouse resources, health links. In particular, the CLAS standards and a report on Interpreter Services for LEP Patients can be found here.
Center for Multicultural and Multilingual Mental Health Services http://www.mc-mlmhs.org/	Created to assist mental health workers in meeting the needs of clients who have a culture and/or language barrier to treatment, the Center is dedicated to bridging the gap between diverse client populations and mainstream mental health provider organizations. A variety of resources, including training materials and publications, are available on this website.
The National Alliance for Hispanic Health, Washington DC http://www.hispanichealth.org/	The NAEH website provides information about Hispanic health issues, patient education materials in English and Spanish, and has a newsletter.

How to reach the National Health Care for the Homeless Council

Improving homeless health care services through the development and implementation of cultural and linguistic competency strategies requires a group effort. As the National Council continues to address the gaps in the provision of culturally and linguistically competent health care services, we encourage any feedback regarding the information presented here or ideas you may have for how the Council can provide support to HCH programs. Ken Kraybill, Training Specialist with the Council, can be reached at kkraybill@nhchc.org.

Notes:

[i] Based on Cross, T., Basron, B., Dennis, k., & Isaacs, M., (1989). *Towards a Culturally Competent System of Care*, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

[ii] Bureau of the Census. *Population Projections for States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2020. Current Population Reports.* Washington, DC: US Dept of Commerce, Bureau of the Census: March 1994. Report P25-1111

[iii] Cohen E., Goode T. Policy Brief 1: *Rationale for Cultural Competence in Primary Health Care.* Georgetown University Child Development Center, The National Center for Cultural Competence. Washington, DC: 1999

[iv] Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic.* Washington, DC: National Academy of Science, March 2002

[v] U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report.* Washington, DC: March 2001. P3-20