

# Maryland Health Disparities Collaborative

## **Cultural and Linguistic Competency Workgroup**

### **Report on Secretary's Request for Assistance (Part II)**

July 31, 2012

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### Report on Secretary's Request for Assistance (Part II)

#### Secretary Sharfstein's Request to the Workgroup for August 2012:

- By August 1, make recommendations to the Maryland Health Care Cost and Quality Council about different levels of cultural and linguistic competence that could factor into a reimbursement system.
- By August 1, make recommendations to the Maryland Health Care Cost and Quality Council about how to support a continuing education system for cultural and linguistic competence.
- By August 1, make recommendations to the Maryland Health Care Commission on how to evaluate the cultural and linguistic appropriateness of information provided to enrollees by health plans.

#### Contents of the Workgroup Response:

- 1. Recommendations to Consider in Factoring Cultural, Linguistic, and Health Literacy Competence into a Provider Reporting and Reimbursement System**
- 2. Recommendations to Support a Continuing Education System for Cultural, Linguistic, and Health Literacy Competence**
- 3. Recommendations for a System to Evaluate the Cultural, Linguistic, and Health Literacy Appropriateness of Health Plan Consumer Information**
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# **Recommendations to Consider in Factoring Cultural, Linguistic, and Health Literacy Competence into a Provider Reporting and Reimbursement System**

## Background:

A multitude of healthcare finance arrangements and provider payment and reporting policies would need to be analyzed by DHMH, the Maryland Health Care Commission, and other entities before considering a system of reporting and tiered reimbursement based on factors related to cultural, linguistic, and health literacy competency. However, the all-payer hospital system in Maryland represents a unique environment in which to consider the potential benefits and challenges.

Payment incentive, or pay-for-performance, programs have been instituted at various levels of the health care system around the country. Health plans have been at the forefront of pay-for-performance programs focused on addressing health disparities issues. For example, Blue Cross Blue Shield (Massachusetts and Florida), and Virginia Premier Health Plan incorporate cultural competency training into their physician pay-for-performance programs.

Over the past several years there has been much concern that payment incentive programs for individual providers could negatively impact racial and ethnic minority communities by reducing access and quality of care, and ultimately widening disparities in health care (Friedberg, 2010; Morris, 2006). In particular, there is a concern that payment incentive programs that are focused on health outcomes may unintentionally provide greater incentives to healthcare professionals whose patient populations are largely not from minority or vulnerable populations, thus creating a disincentive for providers who do provide care for these groups (i.e., Medicaid providers).

In general, although a tiered reimbursement mechanism would seek to align financial reward with improved care delivery practices and health outcomes, the research literature show mixed results on the effectiveness of financial incentive programs on quality improvement overall (Van Herck P et al, 2010) as well as the effect of provider payment incentives in addressing health disparities in particular (Alshamsan et al, 2010). However, further research is required to determine how payment incentive programs fare within organizational environments that incorporate cultural, linguistic, and health literacy competency principles and processes into the organizations' overall strategic planning efforts, as a foundation from which to launch targeted quality improvement and health outcome interventions.

Recently, a national survey sample of 924 hospitals found that 54% of facilities have implemented performance improvement processes aimed at improving the quality of care provided to diverse patient populations (American Hospital Association, 2011). About one-third (32%) of the surveyed hospitals have implemented mechanisms for measuring the quality of culturally and linguistically appropriate services. A similar proportion of the hospitals use race (32%), ethnicity (31%), and primary language (28%) data to analyze patient satisfaction surveys, yet a smaller percentage of hospitals analyze patient satisfaction based on religion (16%), disability status (14%), and sexual orientation (7%). In regard to the hospitals' strategic plans, 54% of the hospitals have included strategic planning components that focus on "improving quality of care for culturally and

linguistically diverse patient populations,” and 32% have guidelines for incorporating cultural and linguistic competency into organizational operations.

**Despite the uncertain effect of health outcome-based payment incentive programs, it still may be possible to consider incentive programs that are based on organizational structure and process measures in place of (or in addition to) outcome measures (Petersen, 2006). Furthermore, the measures could be incorporated into the general reporting systems that currently exist for providers in Maryland.**

#### Recommendations:

**Recommendation 1:** If a tiered reimbursement or other payment incentive program for hospitals (or other category of providers) is determined feasible by the MHQCC Workgroup of the Health Improvement and Disparities Reduction Act, **consider how process measures related to cultural, linguistic, and health literacy competency might be incorporated into the performance evaluation.** Process measures that might be used to gauge the standing of a provider in a tiered reimbursement system should be based on the cultural, linguistic, and health literacy standards recommended by the HHS Office of Minority Health (CLAS Standards) and the National Quality Forum (see Appendices II and III).

Moreover, the **Consumer Assessment of Healthcare Providers and Systems (CAHPS) supplemental survey items on cultural competence and health literacy could be considered as potential outcome measures to incorporate into both the performance evaluation and existing reporting mechanisms.** The Maryland Health Care Commission (MHCC) currently reports on its website the results of the CAHPS Hospital Survey (HCAHPS) among Maryland’s hospitals. HCAHPS is a national, standardized 27-item survey conducted by hospitals quarterly to measure patients’ perceptions of their hospital experience. (Other versions of the survey can be conducted by health plans, clinicians, and group practices.) MHCC reports HCAHPS data as “patient experience”—an outcome measure. By selecting and incorporating survey items from the CAHPS supplemental item sets on cultural competence and health literacy, and analyzing these and other patient experience of care measures by race, ethnicity, and primary language, there is a greater opportunity to identify potential gaps in quality of care. A mechanism would need to be identified to either create an incentive or require hospitals to report the supplemental data and analysis. In addition, **the Maryland Health Care Commission and other entities would need to be consulted to determine if the potential benefits of the new data outweigh the added cost of administering the cultural competence and health literacy survey items.**

Further information about the cultural competence and health literacy item sets for the CAHPS survey is available at the following Web links:

- CAHPS Cultural Competence Item Set – <http://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/Cultural-Competence.aspx>
- CAHPS Health Literacy Item set – <http://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/Health-Literacy.aspx>

**Recommendation 2: Ensure that eligible participation in a tiered reimbursement or other incentive program is structured in a manner that only rewards quality improvement efforts that simultaneously address health disparities.** For example, participation in the incentive program could be limited to providers who meet a minimum threshold percentage of patient population from racial/ethnic minority communities.

**Recommendation 3:** If a payment incentive program is determined not to be feasible, **consider developing a provider quality recognition program that could be implemented at different provider levels** (individual practitioners, group practices, and health facilities). The same process and outcome measures suggested in Recommendation 1 may be transferrable to a provider recognition program. The National Committee for Quality Assurance (NCQA) Distinction in Multicultural Health Care program is one model that may be adaptable to different provider levels (see Recommendation 7 and Appendix IV).

## References

Alshamsan R et al. Impact of Pay for Performance on Inequalities in Health Care: Systematic Review. *J Health Serv Res Policy*, July 2010; 15(3): 178-184.

American Hospital Association, Health Research and Education Trust (HRET). Diversity & Disparities: A Benchmark Study of U.S. Hospitals, 2011. Available at: [http://www.hpoe.org/resources-and-tools/resources/diversity\\_disparities\\_chartbook.pdf](http://www.hpoe.org/resources-and-tools/resources/diversity_disparities_chartbook.pdf)

Friedberg MW, et al. Paying for Performance in Primary Care: Potential Impact on Practices and Disparities. *Health Affairs*, May 2010; 29(5): 926-932.

Internal Revenue Service. Notice 11-52, 2011-30 I.R.B.

Maryland Health Care Commission. Maryland Hospital Performance Guide. Available at: [http://mhcc.maryland.gov/consumerinfo/hospitalguide/hospital\\_guide/reports/find\\_a\\_hospital/patient\\_experience\\_option.asp?hospital\\_nm=210056](http://mhcc.maryland.gov/consumerinfo/hospitalguide/hospital_guide/reports/find_a_hospital/patient_experience_option.asp?hospital_nm=210056)

Morris AW (National Medical Association). Testimony on “How Evidence Based Medicine Will Impact African American Physicians and the Communities They Serve” before the U.S. House of Representatives Committee on Energy and Commerce. (Date: 9/28/2006). Available at: <http://republicans.energycommerce.house.gov/108/hearings/09282006Hearing2045/Morris.pdf>

Petersen LA et al. Does Pay-for-Performance Improve the Quality of Health Care. *Ann Intern Med*, 15 Aug 2006; 145(4):265-272.

Van Herck P et al. Systematic Review: Effects, Design Choices, and Context for Pay-for-Performance in Health Care. *BMC Health Services Research*, 2010; 10-247.

## Recommendations to Support a Continuing Education System for Cultural, Linguistic, and Health Literacy Competence

Background: There is growing national momentum toward improving the cultural, linguistic, and health literacy competency of healthcare providers. With an increasingly diverse population, healthcare providers must be able to negotiate providing care for populations with differing understandings and expectations of their health status and the healthcare system. The goal of training in the cultural, linguistic, and health literacy competencies is to enhance the knowledge, skills, and attitudes of providers so that they may play an even greater role toward improving healthcare consumer satisfaction, improving health outcomes, reducing the costs of care, and ultimately reducing healthcare disparities among state residents. Yet there is considerable variation in the content of cultural competency training of health profession students, both within and across the health disciplines, as found in the 2009 reporting of health profession schools in response to Health-General § 20-1004(15).

Maryland statute signed into law in 2009 (Health-General § 20-1301 et. seq. – “Cultural and Linguistic Health Care Provider Competency Program”), and amended by the recent enactment of House Bill 679, provided for the voluntary development of continuing education programs in cultural competency by the health professional associations in Maryland. To-date, voluntary movement on the issue has not been apparent. However, the states of California, Connecticut, and New Jersey have successfully incorporated cultural competency training into the continuing education requirements for physicians licensed in those states. In the State of Washington, the health boards are authorized (but not required) to offer continuing education in cultural competency.

Although Maryland’s health professional associations have not formally responded to the call for developing continuing education in cultural competency, the **Maryland Board of Examiners of Psychologists requires a minimum of three hours of continuing education activities in cultural competency for license renewal.** The regulation went into effect in December 2010, and the first cohort of licensees affected by the regulation renewed their licenses in March 2012. In addition, it should be noted that although Maryland’s other health occupation boards do not yet require continuing education in cultural, linguistic, or health literacy competency, all of the boards do accept cultural competency training for continuing education credit.

### State Continuing Education Requirements in Cultural Competency

**California** Business and Professional Code § 2190.1 (enacted in 2006):

The Medical Board of California requires all continuing medical education (CME) courses that have a patient care component and are offered by CME providers in California to contain curriculum that includes cultural and linguistic competency in the practice of medicine. Licensees are required to complete 50 CME credits every two years. All CME courses must be accredited by either the California Medical Association or the Accreditation Council for Continuing Medical Education.

**Connecticut** General Statute § 20-10b (enacted in 2010):

The Connecticut Department of Public Health requires one contact hour of education or training

in cultural competency every 2 years. Qualifying continuing medical education activities include, but are not limited to, courses offered or approved by the American Medical Association, American Osteopathic Medical Association, Connecticut Hospital Association, Connecticut State Medical Society, county medical societies or equivalent organizations in another jurisdiction, educational offerings sponsored by a hospital or other health care institution or courses offered by a regionally accredited academic institution or a state or local health department.

**New Jersey** Revised Statute § 45:9-7.2 et. seq. (enacted in 2005):

The New Jersey Board of Medical Examiners requires physicians who were licensed in the State prior to the effective date of the statute to demonstrate participation in cultural competency training as a condition of license renewal. Physicians who obtain a medical degree from a school of medicine in New Jersey after the effective date of the statute are not required to fulfill this continuing education requirement, as the statute includes separate provisions that mandate the inclusion of cultural competency training in the medical school curriculum. Physicians who receive a medical degree at a school of medicine outside of New Jersey and are seeking licensure in the state for the first time are also required to participate in cultural competency continuing education, unless proof of such prior training can be demonstrated. The 6-hour continuing education mandate is a one-time requirement that is not repeated for each license renewal period.

**Washington** Revised Code § 43.70.615 (enacted in 2006):

The Washington State health profession boards are authorized to offer continuing education in cultural competency—the training would be developed in collaboration with health profession education programs in the State. Health boards are also authorized to require that instructors of continuing education programs integrate cultural competency into their curricula when appropriate to the subject matter of the instruction. In a separate provision, the statute requires each health profession training program in the state to incorporate cultural competency training into the curriculum.

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## Recommendations

**Recommendation 4:** Consider the following specifications to support the implementation of continuing education in cultural, linguistic, and health literacy competency:

- A. Requirement of 6 hours of continuing education credit in cultural, linguistic, and health literacy competency during each license renewal period for all of Maryland’s health occupation boards that require continuing education. (The process of developing competency is a lifelong professional development endeavor that cannot be addressed in just a few short courses.) Whether the 6 hours would be “in addition to” or “included in” the existing number of required continuing education credits would be determined by each health occupation board.
- B. Verification of licensee credit would be subject to the same continuing education audit process currently administered by the health occupation boards. In addition to maintaining proof of attendance or course completion, licensees might be expected to keep evidence of the specific

topic areas that were addressed in the training (e.g., course outlines or syllabi, course materials/publications).

- C. Courses, workshops, conferences or other educational programs would be subject to health occupation boards' existing approval process for determining appropriate continuing education sponsors. Examples of potential sponsors may include recognized national and state-based health professional associations, state licensing boards, state or local health departments, accredited academic institutions, hospitals or hospital associations, and other health care institutions in Maryland or in another jurisdiction.
- D. Examples of specific learning objectives to be addressed in the continuing education activities include those listed below. This particular compilation of learning objectives has been vetted by a group of 31 national experts in cultural competency, health literacy, healthcare communication, and minority health, as well as an additional group of 30 educators representing 23 health profession schools in Maryland.

[Note: The learning objectives listed below represent the framework for the Cultural and Health Literacy Competency Primer being developed by a partnership between DHMH Office of Minority Health and Health Disparities and the University of Maryland College Park, School of Public Health and Herschel S. Horowitz Center for Health Literacy.]

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## **Examples of Learning Objectives in Continuing Education in Cultural, Linguistic, and Health Literacy Competency**

### **A. Health Disparities**

#### Knowledge

1. Define Race, Ethnicity, Culture, Health Literacy, and Health Disparities.
2. Identify national and local patterns of data on health disparities and health literacy.
3. Acknowledge barriers to eliminating health disparities (e.g., poverty, lack of health insurance, limited health literacy, limited education, and other social determinants of health).

#### Skills

1. Elucidate the epidemiology of disparities.
2. Critically appraise literature on disparities.
3. Gather and use local data to support Healthy People 2020.

#### Attitudes

1. Recognize disparities amenable to intervention.
2. Value eliminating disparities.
3. Express the attitude that it is the health care professional's duty to elicit and ensure patients' best possible understanding of their health care.

## **B. Community Strategies**

### Knowledge

1. Understand population health variability factors.
2. Describe challenges in cross-cultural communication.
3. Describe community-based elements and resources for helping patients improve health status and general literacy skills.
4. Identify community beliefs and health practices.

### Skills

1. Discuss and describe methods to collaborate with communities to address needs.
2. Describe methods to identify community leaders.
3. Propose a community-based health intervention.

### Attitudes

1. Describe how to address social health determinants.

## **C. Bias and Stereotyping**

### Knowledge

1. Identify how race and culture relate to health.
2. Identify potential provider bias and stereotyping, including assumptions related to health literacy.

### Skills

1. Show strategies to reduce bias in others.
2. Demonstrate strategies to address/reduce bias, including implementing principles of patient communication.
3. Describe strategies to reduce health professional bias.

### Attitudes

1. Value historical impact of racism.

## **D. Effective Communication Skills**

### Knowledge

1. Describe cross-cultural communication, cultural competency and health literacy models and the potential interactions between culture and health literacy in patient/client-provider communication.
2. Recognize patients' spiritual and healing traditions and beliefs.

### Skills

1. Elicit a cultural, social and medical history in the encounter interview in a non-shaming and non-judgmental manner.
2. Assess and enhance adherence, using general and cross-cultural patient/client communication models, health literacy tools, and other health professional assessment tools as appropriate in a non-shaming and non-judgmental manner.

3. Elicit patient's/client's full set of concerns and other appropriate information in a patient/client- or family-centered, nonjudgmental context at the outset of the encounter.
4. Use negotiating and problem-solving skills in conjunction with general and cross-cultural patient/client communication skills to negotiate a mutual agenda with patient at outset of encounter.
5. Practice a "universal precautions" approach with all patients/clients.

#### Attitudes

1. Respect patients'/clients' cultural beliefs.
2. Listen nonjudgmentally to health beliefs.
3. Express the attitude that effective communication is essential to the delivery of safe, high quality health care.
4. Express a non-judgmental, non-shaming and respectful attitude toward individuals with limited literacy (or health literacy) skills.

### **E. Use of Interpreters**

#### Knowledge

1. Describe functions of an interpreter.
2. List effective ways of working with an interpreter.

#### Skills

1. Demonstrate ability to orally communicate accurately and effectively in patients' preferred language, including identifying and collaborating with an interpreter when appropriate.

### **F. Self-Reflection and Culture of Health Professions**

#### Knowledge

1. Describe the provider-patient power imbalance.

#### Skills

1. Engage in reflection about own beliefs.
2. Recognize institutional cultural issues, including issues related to general patient communication.
3. Use reflective practices in patient care.

#### Attitudes

1. Value the need to address personal bias.
2. Express attitude that it is a responsibility of all members of the healthcare team to be trained and proactive in addressing the communication needs of patients.

#### **Sources:**

- Lie DA, Boker J, Crandall S, DeGannes CN, Elliott D, Henderson P, Kodjio C, Seng L. Revising the Tool for Assessing Cultural Competence Training (TACCT) for curriculum evaluation: Findings derived from seven US schools and expert consensus. Med Educ Online [serial online] 2008;13:11. Available at: <http://www.med-ed-online.org>
- Coleman, Hudson, Maine, Culbert. Health Literacy Competencies for Health Professionals: Preliminary results of a Modified Delphi Consensus Study (In Preparation).

**Recommendation 5:** Develop an annual (or more frequent) DHMH-sponsored training event related to one or a combination of the learning objectives listed above. The training event could be developed and conducted through collaboration of the DHMH Training Services Division, the Office of Minority Health and Health Disparities, and an academic or health care institution, association, or other recognized entity approved by the health occupation boards.

**Recommendation 6:** Maintain an up-to-date page on the DHMH/MHHD website that is dedicated to providing information about upcoming cultural, linguistic, and health literacy competency training opportunities. The web page would be accessible to health profession licensees through a link on the homepage of each health occupation board.

## References

California Business and Professional Code § 2190.1.

Code of Maryland Regulations. COMAR 10.36.02 – Department of Health and Mental Hygiene, Board of Examiners of Psychologists, Continuing Education.

Connecticut General Statute § 20-10b.

Maryland Board of Examiners of Psychologists. Newsletter. Winter 2009, Volume 3, Issue 3, pp. 1, 3-4, 6. Available at: <http://dhmh.maryland.gov/psych/pdf/winter3-15-10.pdf>

New Jersey Revised Statute § 45:9-7.2 et. seq.

Washington Revised Code § 43.70.615.

# Recommendations for a System to Evaluate the Cultural, Linguistic, and Health Literacy Appropriateness of Health Plan Consumer Information

## Background:

Based on a Maryland population sample of the National Assessment of Adult Literacy, nearly 40 percent of adults in the state have a basic or below basic level of literacy (Buonasera et al, 2006). This is a clear indicator that not every health consumer in Maryland may be able to successfully navigate the health care system, including understanding information provided by one's health plan—an initial point of access for most consumers.

A recent systematic review of health literacy interventions and outcomes provided evidence that suggests disparities in prescribed treatment outcomes may partly be explained by differences in the health literacy levels of health consumers (HHS/AHRQ, 2011). Even consumers who are highly literate may experience difficulty understanding and utilizing health information.

The issue of health literacy becomes even more complex when one considers the linguistic and cultural diversity of Maryland's population. Nearly 15% of Marylanders age 5 and older speak a language other than English at home; and one out of five Marylanders report that they speak English "not well" or "not at all" (U.S. Census Bureau, 2010). Health plans must address enrollee communication needs concerning language, cultural appropriateness, reading level, health literacy, and preferred channel of communication.

Examples of two states that are working with health plans to address the cultural, linguistic, and health literacy needs of plan enrollees are Indiana and California.

- Indiana requires that any health plan that contracts with the State must incorporate cultural competency standards established by the Department of Health, and the standards must address the needs of non-English speaking, minority, and disabled populations. (Indiana Code § 12-15-44.2-14)
- The California Department of Managed Health Care (DHMC) "requires California health plans to set up a system where services, materials, and information are provided to members in a language that they speak and understand" ([www.dmhc.ca.gov/healthplans](http://www.dmhc.ca.gov/healthplans)). Each health plan is required to develop and implement its own language assistance program and to submit a one-time Cultural Appropriateness Report to the DHMC. The Cultural Appropriateness Report requests that each health plan describe its internal policies and procedures related to cultural appropriateness in each of the following contexts:
  - Methodology used to assess the health plan's enrollee population and the response rate for the survey.
  - Number and frequency of trainings for health plan staff; the training content and type of staff required to attend the trainings; and how the health plan evaluates the effectiveness of staff training.

- Mechanisms used to evaluate the language program and services to the limited English proficient population; how the information is evaluated; and corrective action taken to address problems that are identified.
- Periodic communication to health plan providers regarding the diversity of the health plan's enrollee population and related strategies.
- How the health plan informs enrollees about language assistance services (both interpreter and translation services) and how the health plan is evaluating the effectiveness of such programs.

At a broader national scale, the National Committee for Quality Assurance (NCQA) released the “Standards for Distinction in Multicultural Health Care” in July 2010. The Standards outline five themes for health plans and other organizations to address to earn Multicultural Health Care (MHC) Distinction—a voluntary program to help health plans meet the HHS/Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) Standards. Each of the five themes (race/ethnicity and language data, language services, cultural responsiveness, CLAS services program, and reducing health disparities) includes components that relate directly to assessing the cultural and linguistic appropriateness of health plan communication to enrollees (see Appendix IV). Examples of health plans that currently hold the NCQA Distinction in Multicultural Health Care designation include Kaiser Foundation Health Plan (Georgia and Southern California) and Keystone Health Plan West (a subsidiary of Highmark Blue Cross Blue Shield).

Furthermore, health insurance industry association America's Health Insurance Plans (AHIP) has developed a health literacy toolkit for health plan communicators, in addition to a tool to help health plans conduct an organizational assessment of their health literacy activities (<http://www.ahip.org/HealthLiteracy/>).

## Recommendations

**Recommendation 7: Encourage health benefit plans in Maryland to pursue the NCQA “Distinction in Multicultural Health Care” designation** (possibly even as a condition for participation in the Maryland Health Benefit Exchange); or **incorporate similar elements of cultural, linguistic, and health literacy appropriate communication into the health plan evaluation tools and certification processes currently being developed by the Maryland Health Benefit Exchange and the Maryland Health Care Commission** (i.e., the RELIC tool). The NCQA standards are provided in Appendix IV as one example of the types of data that should be captured to assess whether health plans are making strides to meet the communication and service needs of their diverse enrollee populations.

**Recommendation 8: Require Maryland health plans to incorporate into their current consumer surveys a standardized subset of supplemental items on cultural competence and health literacy** (see Recommendation 1). The Maryland Health Care Commission (MHCC) currently publishes an annual Health Benefit Plan Performance Report that includes member satisfaction as a performance measure category which is broken down by survey question (report available at:

<http://mhcc.maryland.gov/hmo/compreport2011.pdf>). The inclusion of consumer survey results about health plans' abilities to address cultural competence and health literacy needs would enhance the member satisfaction data currently published in the MHCC's report. As in the case of Recommendation 1, **the Maryland Health Care Commission and other entities would need to be consulted to determine if the potential benefits of the new data outweigh the added cost of administering the cultural competence and health literacy survey items.**

## References

America's Health Insurance Plans (AHIP). Website: <http://www.ahip.org/HealthLiteracy/>

Buonasera AK, Baer JD. "Adult Literacy in Maryland: Results from the 2003 State Assessment of Adult Literacy." American Institutes for Research. 2006.

Agency for Healthcare Research and Quality. "Health Literacy Interventions and Outcomes: An Updated Systematic Review." 2011. Available at: <http://www.ahrq.gov/clinic/tp/lituptp.htm>

U.S. Census Bureau. "Language Use in the United States: 2007." Updated November 2010.

Indiana Code § 12-15-44.2-14.

California Department of Managed Health Care. Website: [www.dmhc.ca.gov/healthplans](http://www.dmhc.ca.gov/healthplans).

Maryland Health Care Commission. 2011 Health Benefit Plan Performance Report. Available at: <http://mhcc.maryland.gov/hmo/compreport2011.pdf>

National Committee for Quality Assurance. Multicultural Health Care Distinction. Website: <http://www.ncqa.org/tabid/1195/Default.aspx>

National Health Plan Collaborative to Reduce Disparities and Improve Quality. Website: <http://www.nationalhealthplancollaborative.org>.

## APPENDIX I

### Definitions of Cultural Competency, Linguistic Competency, and Health Literacy

#### Cultural Competency:

A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations.

(Source - Adapted from: Cross T, Bazron B, Dennis K, and Issacs M, "Toward a Culturally Competent System of Care (monograph)," National Technical Assistance Center for Children's Mental Health. 1989.)

#### Linguistic Competency:

The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

(Source - Goode TD, Jones W. "Linguistic Competence." Georgetown University, National Center for Cultural Competence. 2000 (rev. 2009). Available at:  
<http://www11.georgetown.edu/research/gucchd/nccc/documents/Definition%20of%20Linguistic%20Competence.pdf> )

#### Health Literacy:

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

(Source – "Health Literacy," HHS/National Network Libraries of Medicine, last modified May 24, 2012,  
<http://nnlm.gov/outreach/consumer/hlthlit.html>)

## APPENDIX II

### U.S. Department of Health and Human Services Office of Minority Health

#### National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care:

##### Culturally Competent Care:

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. (*Guideline*)
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. (*Guideline*)
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. (*Guideline*)

##### Language Access Services:

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. (*Mandated*)
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. (*Mandated*)
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). (*Mandated*)
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. (*Mandated*)

##### Organizational Supports:

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. (*Guideline*)

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. (*Guideline*)
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated. (*Guideline*)
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. (*Guideline*)
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities. (*Guideline*)
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers. (*Guideline*)
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information. (*Recommended*)

Source: U.S. Department of Health and Human Services, Office of Minority Health. "National Standards for Culturally and Linguistically Appropriate Services in Health Care". 2001. Available at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.

Originally Published in the Federal Register: December 22, 2000 (Volume 65, Number 246, pages 80865-80879).

(Revised CLAS Standards will be released later in 2012. Additional information available at: <https://www.thinkculturalhealth.hhs.gov/>)

## APPENDIX III

### National Quality Forum

#### Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency

##### Domain 1: Leadership

- Preferred Practice 1: Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.
- Preferred Practice 2: Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.
- Preferred Practice 3: Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.
- Preferred Practice 4: Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.
- Preferred Practice 5: Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.
- Preferred Practice 6: Commit to cultural competency through system-wide approaches that are articulated through written policies, practices, procedures, and programs.
- Preferred Practice 7: Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

##### Domain 2: Integration into Management Systems and Operations

- Preferred Practice 8: Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.
- Preferred Practice 9: Implement language access planning in any area where care is delivered.
- Preferred Practice 10: Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.
- Preferred Practice 11: Market culturally competent services to the community to ensure that communities that need services receive the information.

##### Domain 3: Patient-Provider Communication

- Preferred Practice 12: Offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
- Preferred Practice 13: Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.
- Preferred Practice 14: Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.
- Preferred Practice 15: Translate all vital documents, at a minimum, into the identified threshold languages for the community that is eligible to be served.

- Preferred Practice 16: Translate written materials that are not considered vital when it is determined that a printed translation is needed for effective communication.
- Preferred Practice 17: Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document.
- Preferred Practice 18: Use “teach back” as a patient engagement tool to enhance communication between the healthcare provider and the patient during clinical encounters.
- Preferred Practice 19: Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.
- Preferred Practice 20: Regularly assess attitudes, practices, policies, and structures of all staff as a necessary, effective, and systematic way to plan for and incorporate cultural competency within an organization.
- Preferred Practice 21: Include family members in healthcare decisions, when requested by the patient, when providing care for culturally diverse populations.

#### **Domain 4: Care Delivery and Supporting Mechanisms**

- Preferred Practice 22: If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.
- Preferred Practice 23: Develop and implement a comprehensive care plan that addresses cultural concerns.
- Preferred Practice 24: Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.
- Preferred Practice 25: Adapt the physical environment where the healthcare is being delivered to represent the culture of the populations who access their healthcare in that environment.
- Preferred Practice 26: Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.
- Preferred Practice 27: Explore, evaluate, and consider the use of multimedia approaches and health information technology to enable the provision of healthcare services that are patient and family-centered and culturally-tailored to the patient.

#### **Domain 5: Workforce Diversity and Training**

- Preferred Practice 28: Recruit and hire ethnically diverse providers and staff at all levels, including management levels.
- Preferred Practice 29: Actively promote the retention of a culturally diverse workforce through organizational policies and programs.
- Preferred Practice 30: Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.

#### **Domain 6: Community Engagement**

- Preferred Practice 31: Engage communities to ensure that healthcare providers (individual and organizational) are aware of current and changing patient populations and cultural and communication needs and provide opportunities to share resources and information.
- Preferred Practice 32: Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.
- Preferred Practice 33: Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating the effectiveness of cultural competency activities.

- Preferred Practice 34: Healthcare professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.
- Preferred Practice 35: Use the methodology of community-based participatory research when conducting research in the community as a collaborative approach to research that equitably involves all stakeholders in the research process and fosters the unique strengths that the community brings to the process.

### **Domain 7: Data Collection, Public Accountability, and Quality Improvement**

- Preferred Practice 36: Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner.
- Preferred Practice 37: Ensure that, at a minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.
- Preferred Practice 38: Utilize indirect data collection methodologies (e.g., geocoding, surname analysis) to characterize the race, ethnicity, and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.
- Preferred Practice 39: Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.
- Preferred Practice 40: Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.
- Preferred Practice 41: Publicly report data for the applicable NQF-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care stratified by race/ethnicity and primary written and spoken language.
- Preferred Practice 42: Regularly make available to the public information about progress and successful innovations in implementing culturally competent programs (especially the NQF-endorsed preferred practices for cultural competency), and provide public notice in communities about the availability of this information.
- Preferred Practice 43: Assess and improve patient- and family-centered communication on an ongoing basis.
- Preferred Practice 44: Any surveys created by or conducted by the organization must collect race, ethnicity, and primary written and spoken language, and analysis and results must be stratified by race, ethnicity, and primary written and spoken language.
- Preferred Practice 45: Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.

Source: National Quality Forum. "Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competence: A Consensus Report," 2009. Available at: [http://www.qualityforum.org/Publications/2009/04/A\\_Comprehensive\\_Framework\\_and\\_PREFERRED\\_Practices\\_for\\_Measuring\\_and\\_Reporting\\_Cultural\\_Competency.aspx](http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_PREFERRED_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx)

## APPENDIX IV

### National Committee for Quality Assurance (NCQA) Standards for Multicultural Health Care Distinction

#### MHC 1: Race/Ethnicity and Language Data

The organization gathers race/ethnicity and language data using standardized methods.

Intent: The organization collects information that helps it provide culturally and linguistically appropriate services (CLAS).

##### Element A: Collection of Data on Race/Ethnicity

The organization's methods to assess the race/ethnicity of its eligible individuals include the following:

1. Direct collection of data from eligible individuals
2. Estimation of race/ethnicity using indirect methods
3. Validation of estimation methodology
4. Process to roll up race/ethnicity data to Office of Management and Budget (OMB) categories
5. System for data storage and retrieval of individual-level data
6. Reporting HEDIS *Diversity of Membership* measures (race/ethnicity component), if applicable.

##### Element B: Collection of Data on Language

The organization's methods to assess the language needs of its eligible individuals include the following:

1. Direct collection of language needs from health plan enrollees
2. A system for data storage and retrieval of language data
3. Assessment of the enrollee population's language profile at least every three years
4. Determination of threshold languages (spoken by at least 5% of the population or 1000 health plan enrollees)
5. Determination of languages spoken by at least 1% of the population or 200 health plan enrollees
7. Reporting the HEDIS *Diversity of Membership* measures (language component), if applicable.

##### Element C: Privacy Protections for R/E/L Data

The organization has policies and procedures for managing access to and use of race/ethnicity and language data, including:

1. Controls for physical and electronic access to the data
2. Permissible uses of the data
3. Impermissible uses of the data, including underwriting and denial of coverage and benefits

##### Element D: Notification of Privacy Protections

When the organization collects data, it discloses to eligible individuals its policies and procedures for managing access to and use of race/ethnicity and language data, including:

1. Controls for physical and electronic access to the data
2. Permissible uses of the data
3. Impermissible uses of the data, including underwriting and denial of coverage and benefits

## **MHC 2: Access and Availability of Language Services**

The organization provides materials and services in the languages of health plan enrollees.

Intent: The organization communicates effectively with eligible individuals.

### Element A: Written Documents

The organization has a documented process for providing vital information in threshold languages that includes:

1. Use of competent translators
2. A mechanism for providing translations in a timely manner
3. Specifying when translations will be written and when oral interpretation of written information will be provided
4. A mechanism for evaluating the quality of the translation

### Element B: Spoken Language Services

The organization uses competent interpreter or bilingual services to communicate with enrollees who need to communicate in a language other than English.

### Element C: Support for Language Services

The organization supports practitioners in providing competent language services, including:

1. Sharing data with practitioners on language needs of enrollees
2. Sharing organization or service area population data on language needs
3. Providing practitioners with language assistance resources
4. Making in-person, video or telephone interpretation services available to practitioners
5. Offering training to practitioners on the provision of language services

### Element D: Notification of Language Services

Annually, the organization distributes written notice in English and any languages spoken by at least 1% or 200 health plan enrollees, whichever is less, up to a maximum of 15 languages, that the organization provides free language assistance, and how the enrollee can obtain the service.

## **MHC 3: Practitioner Network Cultural Responsiveness**

The organization maintains a practitioner network that is capable of serving its diverse membership and is responsive to member needs and preferences.

Intent: The organization maintains a practitioner network that can meet the cultural and linguistic needs of its members.

### Element A: Assessment and Availability of Information

To enable members to choose practitioners best able to meet their cultural and linguistic needs, the organization:

1. Collects information about languages in which a practitioner is fluent when communicating about medical care
2. Collects information about language services available through the practice

3. Collects practitioner race/ethnicity data
4. Publishes practitioner languages in the provider directory
5. Publishes language services available through the practice in the provider directory
6. Provides practitioner race/ethnicity on request

**Element B: Enhancing Network Responsiveness**

At least every three years, the organization:

1. Analyzes the capacity of its network to meet the language needs of its members
2. Analyzes the capacity of its network to meet the needs of its members for culturally appropriate care
3. Develops a plan to address any gaps identified as a result of the analysis
4. Acts to address any gaps based on its plan

**MHC 4: Culturally and Linguistically Appropriate Services Programs**

The organization continually improves its services to meet the needs of multicultural populations.

Intent: The organization improves care and services for all eligible individuals.

**Element A: Program Description**

The organization has a written program description for improving culturally and linguistically appropriate services that includes the following:

1. A written statement describing the organization's overall objective for serving a culturally and linguistically diverse population
2. A process to involve members of the culturally diverse community in identifying and prioritizing opportunities for improvement
3. A list of measurable goals for the improvement of Culturally and Linguistically Appropriate Services (CLAS) and reduction of health care disparities
4. An annual work plan
5. A plan for monitoring against the goals
6. Annual approval by the governing body

**Element B: Annual Evaluation**

There is an annual written evaluation of the culturally and linguistically appropriate services program that includes the following:

1. A description of completed and ongoing activities for culturally and linguistically appropriate services
2. Trending of measures to assess performance
3. Analysis of results of initiatives, including barrier analysis
4. Review and interpretation of the results by community representatives
5. Evaluation of the overall effectiveness of the program

## **MHC 5: Reducing Health Care Disparities**

The organization uses race/ethnicity and language data to assess the existence of disparities and to focus quality improvement efforts towards improving the provision of culturally and linguistically appropriate services and decreasing health care disparities.

Intent: The organization uses data about its population to improve services and reduce disparities.

### **Element A: Use of Data to Assess Disparities**

The organization uses race/ethnicity and language data and the following methods to determine if health care disparities exist.

1. Analyze one or more valid measures of clinical performance, such as the HEDIS survey, by race/ethnicity
2. Analyze one or more valid measures of clinical performance, such as the HEDIS survey, by language
3. Analyze one or more valid measures of enrollee experience, such as the CAHPS survey, by race/ethnicity or language

### **Element B: Use of Data to Monitor and Assess Services**

The organization assesses the following at least annually:

1. Utilization of language services for organization functions
2. Enrollee experience with language services for organization functions
3. Staff experience with language services for organization functions
4. Enrollee experience with language services during health care encounters

### **Element C: Use of Data to Measure CLAS and Disparities**

Based on the results of measurement of health care disparities and language services, the organization annually:

1. Identifies and prioritizes opportunities to reduce health care disparities
2. Identifies and prioritizes opportunities to improve CLAS
3. Implements at least one intervention to address a disparity
4. Implements at least one intervention to improve CLAS
5. Evaluates the effectiveness of an intervention to reduce a disparity
6. Evaluates the effectiveness of an intervention to improve CLAS

Source: National Committee for Quality Assurance. Standards for Multicultural Health Care, 2010. Available at: <http://www.ncqa.org/tabid/1157/Default.aspx>

## Cultural and Linguistic Competency Workgroup - List of Workgroup Members

Name	Organization
Austin, Sandra	Morgan State University, School of Social Work
Bohrer Brown, Pamela	Baltimore Medical System
Braun, Bonnie	Department of Family Science, School of Public Health, UMD
Carnahan, Rebecca	Arthritis Foundation
Carter Pokras, Olivia	UMD SPH
Chung, Elizabeth	The Learning Institute for Enrichment and Discovery, Inc. (LIFE & Discovery)
Dashiell, Terrie	Community Health Education, Lifebridge Health
Davis, Danielle	Maryland Health Benefit Exchange
Dunmeyer, Ines	
Fields, Kisha	Maryland Board of Examiners of Optometry
Foletia, Bako	
Garcia, Katherine	Center for health Literacy, University of Maryland
Gibbs, Brian	Johns Hopkins University
Gold, Robert	University of Maryland School of Public Health
Green, Denesecia	Centers for Medicare & Medicaid Services
Hackshaw, Bibi	Esperanza Center
Henson, Sonya	
Hiner, Kimberly	Maryland Office of Minority Health and Health Disparities
Howard, Sylvette	
Hussein, Carlessia	Maryland Office of Minority Health and Health Disparities
Jackson Bowen, Darlene	University of Maryland Eastern Shore
Jacobs, Donna	Government and Regulatory Affairs, University of Maryland Medical System
Joseph, Malcolm III (Vice Chair)	CareFirst

<b>Kenez, Dennis</b>	
<b>Kick, Sandy</b>	<b>Maryland Women's Coalition for Health Care Reform</b>
<b>Lee, Candace</b>	
<b>Lee, Keona</b>	
<b>McCann, Monica (Staff)</b>	<b>Maryland Office of Minority Health and Health Disparities</b>
<b>Mensah, Oscar</b>	
<b>Mezu, Alicia</b>	<b>Maryland State Department of Education</b>
<b>Mittman, Ilana (Chair)</b>	<b>Johns Hopkins Bloomberg School of Public Health, Department of Epidemiology, Center to Reduce Cancer Disparities</b>
<b>Nathan Pulliam, Shirley</b>	<b>Maryland General Assembly</b>
<b>Neels, Deborah</b>	<b>University of Maryland, Baltimore</b>
<b>Nussa, Caridad Morales</b>	<b>Baltimore County Department of Health</b>
<b>Nwabukwu, Ify Anne</b>	<b>African Women's Cancer Awareness Association</b>
<b>O'Neill, Tricia</b>	<b>Academic Affairs, University of Maryland Baltimore</b>
<b>Pesquera, Marcos</b>	<b>Adventist Health Care, Center for Health Disparities</b>
<b>Philipsen, Nayna</b>	<b>College of Health Professions, Coppin State University</b>
<b>Plasencia, Francisco</b>	<b>Esperanza Center</b>
<b>Powell, Lauren</b>	<b>NIH- National Cancer Institute, Division of Cancer Treatment and Diagnosis, Office of the Director</b>
<b>Qin, Wendy</b>	<b>HCD International</b>
<b>Ragsdale, Steven</b>	<b>Armstrong Institute</b>
<b>Reeves, Iris</b>	<b>Mental Hygiene Administration</b>
<b>Rivera, Maritza</b>	<b>UME</b>
<b>Ruey-Hwa, Lu</b>	
<b>Schwarz, Ellen</b>	<b>Primeros Pasos, Kennedy Krieger Institute</b>
<b>Scott, Jacqueline R.</b>	<b>National Academy for State Health Policy</b>
<b>Seagraves, Missy</b>	<b>Life and Discovery</b>

<b>Shah, Priyanka</b>	<b>DHMH</b>
<b>Smith, Andy</b>	<b>Brothers United Who Dare to Care, Inc.</b>
<b>Stokes-Smith, Robin R.</b>	<b>Upper Chesapeake Healthlink</b>
<b>Terry, Tequila</b>	<b>Maryland Health Benefit Exchange</b>
<b>Tschudy, Megan</b>	<b>Johns Hopkins - Pediatrics, Hamet Lane Clinic</b>
<b>Wilcox, Mark</b>	<b>Merit*Baltimore</b>
<b>Williams, Ralph</b>	<b>Access to Wholistic and Productive Living Inc.</b>
<b>Wilson, Cheri</b>	<b>Johns Hopkins Bloomberg School of Public Health/Hopkins Center for Health Disparities</b>