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Disability Awareness Brief:

*CULTURAL COMPETENCY**

June, 2015

Note: This is one in a series of six Disability Awareness Briefs: Introduction to Disability Awareness, Disability Competency for Providers, Disability Competency for Care Management Practitioners, Cultural Competency, Accessibility, and Universal Design. This Brief on Cultural Competency should be considered together with the other five documents in order to have the comprehensive, basic information needed to inclusively address the unique health care needs of individuals with disabilities.

WHAT IS CULTURAL COMPETENCY?

Cultural competence is the ability to relate effectively to individuals from various groups and backgrounds, and to recognize the broad scope of influences on an individual's personal identity. Culturally competent services respond to the unique needs of members of various groups and are sensitive to the ways they experience the world.[1]

Culture can be defined as the behaviors, values and beliefs shared by a group of people. Characteristics that can define cultural groups include, but are not limited to:[2]

- Race
- Ethnicity
- Country Of Origin
- Language
- Sexual Orientation
- Gender Identity / Transgender
- Age
- Education
- Disability
- Family and Household Composition
- Class/Socioeconomic Status
- Religious/Spiritual Orientation
- Political Beliefs
- Geography
- Refugee Status
- Tribal Affiliation
- Military Affiliation

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Everyone belongs to multiple cultural groups, so that each individual is a blend of many influences. Culture also is dynamic in nature, and individuals may identify with multiple different cultures over the course of their lifetimes. Culture includes or influences dress, language, religion, customs, food, laws, codes of manners, behavioral standards or patterns, and beliefs. It plays an important role in how people express themselves, seek help, cope with stress and develop social supports. Culture affects every aspect of an individual's life, including how we experience, understand, express, and address physical, emotional, and mental distress.

Cultural competence does not mean knowing everything about every culture. It does mean understanding that beliefs and attitudes about health, illness and disability vary from culture to culture and, as a result, responses to providers and to treatment, services and supports also may vary. It also means being curious about other cultures, becoming aware of one's own cultural biases, and being sensitive to cultural differences while avoiding stereotypes.[3] Cultural competence also includes the provision of health care in the language that is preferred by the individual and/or meets the needs of all individuals, including those who have low literacy skills or are not literate.

WHY IS IT IMPORTANT THAT PROVIDERS HAVE CULTURAL COMPETENCY?

It is imperative that providers understand cultural differences and become culturally competent in order to provide quality care. The nation's population is rapidly diversifying, and this also is true in Vermont. The percentage of racial and ethnic minorities, refugees, and people who speak English as a second language are all increasing in the state.[4]

Recognition of disability culture also is growing internationally and in Vermont. Although the range of differences among individuals with disabilities is enormous, the common bonds within disability culture are twofold: 1) a recognition of the impact of social beliefs and practices on the experience of disability, and 2) the acknowledgement and celebration of disability as a way of life, rather than a life that is tragic or devalued. This shared understanding reframes/remakes the concept of disability, allowing individuals with a disability to claim disability *and* dignity, visibility, and self-value. The common bond created by disability culture creates powerful opportunities for individuals with diverse disability experiences to pursue personal goals while working together to establish disability rights and social equality.[5]

There are many cultural barriers that prevent individuals from receiving appropriate and quality care. These include mistrust and fear of treatment; alternative ideas about

disability and about what constitutes illness and health; language barriers and ineffective communication; access barriers, such as inadequate insurance coverage, or inaccessible architectural and structural design; and a lack of diversity in the health care workforce. In addition, people who have refugee status, have trauma histories related to war and loss of country, or are new to United States culture often find it difficult to understand and access our unfamiliar "system of care". Furthermore, cultural biases and stereotypes can cause inequity in service provision and can prevent people from seeking help.[6] Physicians may be especially vulnerable to the use of stereotypes in forming impressions of individuals since time pressure, brief encounters, and the need to manage very complex tasks are common characteristics of their work.[7]

Recent federal laws have been enacted to reinforce the need for cultural competency in the health care and services arena. Section 1557 of the Affordable Care Act of 2010 prohibits discrimination in health care programs on the basis of race, color, national origin, sex, sex stereotypes, gender identity, age, or disability. The Department of Health and Human Services' Office for Civil Rights holds the authority and obligation to investigate potential violations of the law and enforce this new civil rights guarantee.[8]

More recently, in 2013 the U.S. Department of Health and Human Services, Office of Minority Health published enhanced national *Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. The CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services.

Although implementation of the enhanced National CLAS Standards is not mandated by federal law, failure to provide services consistent with Standards 5 through 8 (see below) could result in a violation of Title VI of the Civil Rights Act of 1964 regulation that requires recipients of Federal financial assistance to take reasonable steps to provide meaningful access to their programs for persons with limited English proficiency.[9]

The following pages present the fifteen CLAS standards, which as a whole represent organizational opportunities to address health care disparities at every point of contact along the health care services continuum. The first is the Principal Standard which guides all others; Standards 2 through 15 represent the practices and policies that are the fundamental building blocks of culturally and linguistically appropriate services necessary to achieve the Principal Standard.

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Advanced and sustained organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruitment, promotion, and support for a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educated and trained governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
5. Offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
9. Establishing culturally and linguistically appropriate goals, policies, and management accountability, and infusing them throughout the organization's planning and operations.
10. Conducting ongoing assessments of the organization's CLAS-related activities and integrating CLAS-related measures into measurement and continuous quality improvement activities.
11. Collecting and maintaining accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conducting regular assessments of community health assets and needs and using the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partnering with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Creating conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicating the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

INDICATORS OF CULTURAL COMPETENCY: [10]

Following are examples of cultural competency:

ORGANIZATIONAL CHARACTERISTICS:

- Organizational governance, leadership, policies and procedures that are committed to the implementation of the CLAS standards and the provision of culturally competent care.
- Identifying and developing informed and committed champions of cultural competency throughout the organization to focus efforts around the provision of culturally competent care.
- Surveying staff to elicit their cultural biases and understanding of cultural competence and culturally competent practice, and providing training to address staff educational needs.
- Intake and service delivery documentation, policies and procedures that are inclusive, and ensuring that they:
    - Are accessible to individuals from culturally diverse backgrounds.
    - Recognize that refugees and others new to the U.S. may be coming from cultures with different expectations of the role the family, the individual, and the government, or the availability of government services.
    - Recognize that refuges may have different trust levels of the government, and may have limited knowledge of "individual rights" to request services from the government.
    - Are supportive of the provision of trauma-informed care.
- Employing staff that is fluent in the languages of the groups being served.
- Ensuring that staff is fully aware of, and trained in, the use of language assistance services, policies, and procedures.
- Providing ready access to interpreter services in person and on the phone.
- Printed information that takes into account the typical literacy levels of individuals and families receiving services.
- Having easy to complete forms, and offering assistance in completing the forms.
- Displaying pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of people served by the organization.

- Establishing accountability mechanisms throughout the organization, including staff evaluations, satisfaction measures, and quality improvement measures.
- Providing notice about the right of each individual to provide feedback, including the right to file a complaint or grievance, in translated signage and materials.

PROVIDER KNOWLEDGE:

- Knowledge of the CLAS standards and how to apply them when working with culturally diverse individuals.
- Readiness to Address Cultural Differences:
    - Knowledge of the impact of culture on health, illness, health practices, health beliefs, access to care, and participation in treatment and services.
    - Knowledge of the role of social functioning and family in health, illness, health practices, responses to disability, health beliefs, and participation in treatment and services.
    - Recognizing that people from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
    - Understanding that family is defined differently by different cultures (e.g. extended family members, godparents) and that male-female roles may vary significantly among different cultures (e.g. who makes major decisions for the family).
    - Understanding that age and life cycle factors must be considered in interactions with individuals and families from different cultures (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
    - Awareness of the socio-economic and environmental risk factors that contribute to health and mental health disparities or other major health problems of culturally and linguistically diverse populations served.
    - Keeping abreast of the major health and mental health concerns, disparities and issues for ethnically and racially diverse client populations residing in the geographic locale served.
- Capacity to Address Language Barriers:
    - Recognizing that limitations in English proficiency do not reflect the individual's level of intellectual functioning or their ability to communicate effectively in their language of origin.
    - Recognizing that individuals may not be literate in their language of origin nor in English.

PROVIDER SKILLS/BEHAVIORS:

- Addressing Communication Barriers:
  - When possible, attempting to learn and use a few key words of the language used by individuals and families who speak languages or dialects other than English to increase the ability to communicate with them during assessment, treatment, and other interventions and services.
  - Attempting to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, health promotion and education or other interventions.
  - Using alternatives to written communications for some individuals and families, as this may not be the preferred method of receiving information.
- Avoiding Disrespect and Bias:
  - Avoiding the imposition of values that may conflict or be inconsistent with those of cultures or ethnic groups different than that of the provider.
  - Intervening in an appropriate manner when observing other staff or service recipients engaging in behaviors that show cultural insensitivity, racial biases, or prejudice.
  - Screening materials, books, and other resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families receiving services.
  - Before visiting or providing services in the home setting, seeking information on acceptable behaviors, courtesies, customs, and expectations that are unique to the person's culture.
  - Developing culturally sensitive plans of care.
  - Advocating for the review of the organization's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.
- Assessing Cultural Norms and Related Needs:
  - Seeking information from individuals, families or other key community members that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups.
  - Using open-ended questions to identify each person's cultural outlook.
  - Identifying resources, such as natural supports, within the person's cultural community that can assist the person with their needs.
  - Taking professional development courses and training to enhance knowledge and skills in the provision of services and supports to culturally and linguistically diverse groups.

[1] *Cultural Competence in Mental Health.* Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities. Temple University: Philadelphia, Pennsylvania. Available at: http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Cultural_Competence_in_MH.pdf

[2] *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* U.S. Department of Health and Human Services, Office of Minority Health; April, 2013. Available at: https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

[3] *Cultural Diversity in Vermont*. Vermont Department of Health; Burlington, VT. Available at: http://healthvermont.gov/family/toolkit/tools%5CF-1%20Cultural%20Diversity%20in%20Vermont.pdf

[4] *ibid.*

[5] *What is Disability Culture?* Brown SE. Disability Studies Quarterly: Spring 2002, Volume 22, No. 2. Available at: http://dsq-sds.org/article/view/343/433

[6] *Cultural Competence in Mental Health.* Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities. Temple University: Philadelphia, Pennsylvania. Available at: http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Cultural_Competence_in_MH.pdf

[7] *Mental Health Services in Primary Care.* Center for American Progress: Washington, DC; October 2010. Available at: https://www.americanprogress.org/wp-content/uploads/issues/2010/10/pdf/mentalhealth.pdf

[8] *Do the Right Thing: Culturally Responsive Healthcare and the Federally Mandated CLAS Standards.* Health Management Associates Information Services Webinar; March 12, 2105. Available at: http://www.healthmanagement.com/news-and-calendar/article/350

[9] *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* U.S. Department of Health and Human Services, Office of Minority Health; April, 2013. Available at: https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

[10] This information was obtained from the following sources:

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- *Provider- and Practice-Level Competencies for Integrated Behavioral Health in Primary Care: A Literature Review.* Carissa R. Kinman CR, Gilchrist EC, Payne-Murphy JC, Miller BF. Agency for Healthcare Research and Quality: Rockville, MD; March 2015. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/mental/index.html
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