As a result of the many shifts being experienced by communities all over the nation, health centers are in a unique and challenging situation. Changes in ethnic diversity are not only statistically significant but, more importantly, they increase potential cultural differences. This situation often requires staff to assess how adequately a healthcare facility is bridging cultural differences or what can be done in order to overcome differences also due to language or education. This issue of Migrant Health Newsline focuses on such barriers and includes articles such as a review of the CLAS Standards, a definition of culture and tips on cross-cultural communication.

Understanding the Culturally and Linguistically Appropriate Services (CLAS) Standards
by Evangelina Orozco, Leadership Development and Training Specialist, NCFH

An excellent guide that assists organizations in insuring that patients from all backgrounds are receiving high quality health care is the Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards are a set of mandates, guidelines, and recommendations issued by the U.S. Department of Health and Human Services’ Office of Minority Health (OMH, 2001). They inform, guide, and facilitate best practices related to culturally and linguistically appropriate health services. Their intent is to make health care practices more respectful and responsive to the cultural and linguistic needs of patients from all backgrounds. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

When considering each of these standards, take a mental walk of your health care center and facilities. Think about the many points of impact at your health center or clinic and where you have an opportunity to make a difference in the service you provide to your patients and customers. Here are some examples of health center points of impact:

- Front desk
- Waiting room
- Educational materials/forms
- Nursing station
- Exam room
- Discharge area
- Signage
- Staff

All points of service affect the patient’s experience in the health center. For example, the front desk is critical to setting the stage for the healthcare experience. The procedures used and the way staff interact with patients will create one of the first impressions that patients develop about your clinic and your services. Negative consequences, such as feelings of being insulted or being treated rudely, fear of contacting the health care provider or health center, or confusion about appointments or treatments, may result when the front desk fails to use culturally and linguistically competent practices. The health center can face problematic outcomes too, such as time wasted due to missed appointments and the loss of patients and income to other medical providers. Further, you can also lose referrals and a good reputation if families report to others their negative experiences with the front desk. Similarly, how patients experience other points of impact, such as how they are treated by staff at the nursing station or exam room, or a patient’s ability to understand the written information provided to them, can greatly affect the quality of health care received.

As you read the next section on the CLAS standards, consider how you can make your health center’s various “points of impact” better by implementing each CLAS standard. What should that point of impact look like and feel like to the patient that speaks limited English, or to the patient that is a new to your community? For each standard, ask yourself, what one thing, whether big or small, can you implement to improve the cultural and/or linguistic interaction and/or communication of that point of impact.

The CLAS Standards
The fourteen standards are organized by themes: Culturally Competent Care (Standards...
1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying strictness: mandates, guidelines, and recommendations. Mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7). Guidelines are activities recommended for adoption as mandates by Federal, State, and National accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13). Finally, recommendations are suggested for voluntary adoption by health care organizations (Standard 14).

Culturally Competent Care

**Standard 1:** Health care organizations should ensure that patients/consumers receive from all staff member’s effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

**Standard 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.

**Standard 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.

Language Access Services (mandated)

**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.

Organizational Supports

**Standard 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.

**Standard 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.

**Standard 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.

**Standard 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.

**Standard 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.

**Standard 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.

**Standard 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.

The National Center for Cultural Competence has developed a Self-Assessment checklist for health care providers that can serve as an excellent resource for assessing where you are in the implementation of the CLAS standards. The Self-Assessment is titled *Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health Care Services.*
Defining Culture and its Impact on Practice
by Evangelina Orozco, Leadership Development and Training Specialist, NCFH

Culture as the Iceberg Model

Culture is defined as a body of learned beliefs, traditions, and guides for behaviors that are shared among members of a particular group. It shapes our behaviors and serves as a roadmap for both perceiving and interacting with the world. Culture is passed on from generation to generation, but it is constantly, though slowly, changing. In his book, *Beyond Culture* (1976), Edward T. Hall likens culture to an iceberg in that there are things we can plainly see about it that are on the surface such as music, dress, foods, and sports. These are the elements we first notice when visiting a new country. But these things alone do not represent a person’s culture. There are aspects of culture that we cannot see, but that actually represent the greater part of one’s culture. These deeper aspects of culture are about beliefs, values and thought patterns that guide people’s actions and are the more significant components of defining one particular culture. Some examples include:

Practical Spanish for Medical Personnel
by Maria de Lourdes Garcia, 1985.

This helpful dictionary and booklet translates very common terminology that is used in the healthcare setting with respect to symptoms, conditions and treatment. The table of contents breaks down different components of the healthcare process from general medical history and anatomical terms to pediatrics and the physical examination. It also gives a quick overview of Spanish for those who are beginners to the language.

What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency
by Dennis Andrulis and others, 2002.

This study compares the perceptions and experiences of adults who needed interpreters and were provided one with those who were not provided one. Several significant conclusions were drawn from the study based on the provision of an interpreter: 1) Respondents who were provided with an interpreter were more likely to describe the facility as “open and accepting;” 2) A significant number of patients who need an interpreter but were not provided an interpreter were not asked if they needed financial assistance. The article draws interesting parallels between providing interpreters and the effective delivery of healthcare.

The NCFH Resource Center and Library houses a collection of relevant, up-to-date and electronically-accessible information on farmworker health for the purpose of educating the general population and collecting the latest findings on farmworker healthcare research and data. The following is a list of resources within the NCFH Library that can assist those interested in learning more about cultural competency or language barriers within the healthcare setting. For questions on these or any other resources, please contact Erika Garcia.
how people think and feel about their own health,
when and from whom people seek care,
how people respond to recommendations for lifestyle change and treatment (such as changes to diet, etc.), and
how health care professionals communicate with their patients.

For instance, many patients will follow their own culture’s traditional or folk medicine treatments even when they are under the care of a medical doctor. Providers may need to accept this, discuss it openly, and find a way to negotiate with that patient to ensure that the disease will be properly addressed with both biomedical western treatments and alternative, non-western treatments.

Even before the point of interaction between the health care provider and patient, culture affects health care because it affects people’s health belief systems and how a health problem is solved. Different cultural groups view the following ideas differently:

- how they define and categorize health and illness,
- how they explain illness and what causes it,
- how they view cause and effect between illness and treatments,
- how they define the “scope of practice” for healers or doctors, and
- when they seek health care.

Developing Cultural Competency

Cultural competency is one of the main ingredients in closing the disparities gap in health care. Cultural competency has been defined as “a set of congruent values, behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations” (adapted from Cross, 1989). It is the ability of health organizations as a whole, and of each individual practitioner in each of their roles, to recognize cultural beliefs, values, attitudes, traditions, language preferences and the health practices of different populations, and the ability to apply that knowledge to produce a positive health outcome. Quite simply, cultural competent health care services are respectful of attitudes toward life and death, structure and expectations of the family, concept of time, etc. It takes time to become aware of and understand these deeper elements of culture, which tend to impact interpersonal relations, communication, health care beliefs, and actions much more than the superficial things that we usually may perceive as culture. Failure to understand and recognize these elements of culture and the layers that compose them, as well as how they influence each other is the main reason misunderstandings occur when interacting across cultural groups.

Variations within Cultural Groups

When we think of culture, we tend to make assumptions or generalizations based on one characteristic, such as race, but in reality, a person’s culture is shaped by multiple influences, that can include nationality, language, gender, socioeconomic status, occupation, religious beliefs, education, legal status, and level of acculturation to their place of residence. We must consider these factors when looking at individuals within the same cultural group. For example, a young person and an elderly person in the same family may have completely different viewpoints on an issue, even though they are in the same “cultural group”. It is important to recognize that making assumptions or generalizations about a person based on a group they belong to may lead to erroneous conclusions. The key is that in every interaction you have with others, you avoid the misunderstandings that can happen by placing people into “boxes.”

Effects of Culture on Health Care

It is impossible to underestimate the impact that culture can have on health care. Culture affects all of the following:

- how people communicate and understand health information,
Organizations must have:
- Policies and procedures in place that value diversity (Implementing the CLAS standards is a way to ensure a more culturally competent environment that supports its staff and patients),
- Self-assessments, and
- Acquired and institutionalized cultural knowledge and adaptation to the diversity and cultural contexts of the individuals and communities served. (Can be achieved through staff development and training)

Achieving cultural competency is a developmental process that evolves over time and requires a commitment to expand your knowledge, skills and communications as you interact with your patients.

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**Tips on Cross-Cultural Communication**
by Evangelina Orozco, Leadership Development and Training Specialist, NCFH

A basic understanding of cultural characteristics is the key to effective cross-cultural communications. We need to learn to recognize and honor cultural differences and also be able to maintain a positive attitude towards those differences. Below are some suggestions for creating a positive cross-cultural communication applicable to a health care setting, regardless of your role.

- Learn about cultural appropriate ways to greet people
- Learn correct pronunciation of names
- Avoid assumptions, always ask questions
- Be sensitive to topics that may be taboo
- Avoid use of slang, idioms, and jargon
- Recognize the meaning of non-verbal communication (consider personal space and touch
- When using an interpreter, speak directly to the patient

Developing cross-cultural communications skills can lead to more successful interactions between providers and patients from all cultural backgrounds. Skillfulness in cross-cultural communication with patients can be demonstrated by a provider’s comfort with asking key questions so that he or she may discover the broader context in which a patient is operating.

Below you will find sample questions that health care providers can ask to improve cross-cultural communication, and convey understanding and respect. (Adapted from medical anthropologist Arthur Kleinman’s *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*, 1981).

- What do you think caused your problem? Why do you think it started when it did?
- What do you think your sickness does to your body? How does it work?
- How severe is your sickness? How long do you think it will last?
- What are the main problems your sickness has caused you?
- Do you know others who have had this problem? What did they do to treat it?
- Did you discuss your problem with any of your relatives and friends? What did they say?
- What kinds of medicines, home remedies or other treatments have you tried for this sickness? Did they help? Are you still using them?
- What type of treatment do you think you should receive from me? What are the most important results you hope to receive from this treatment?
- Do you think there is any way to prevent this problem in the future? How?
- Is there any other information that might help us design a treatment plan?
Implementing Effective Language Services in Health Care Organizations

By Mara Youdelman, J.D., LL.M., Managing Attorney, National Health Law Program and Chair, Certification Commission for Healthcare Interpreters

In the health care system, where complex medical terminology leave many English speakers confused or misinformed, language barriers not only increase confusion, but open the door to misdiagnoses, non-compliance and unnecessary or redundant medical tests, all leading to a lesser quality of care and contributing to racial and ethnic health disparities for patients who are limited English proficient (LEP).

There is ample research as to the disparities in access and quality of care suffered by LEP individuals who do not have access to competent interpreters to ensure effective communication with healthcare providers and insurers. According to a survey cited in the Institute of Medicine’s report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health, 51% of providers believed patients did not adhere to treatment because of culture or language. Language barriers also impact access to care – non-English speaking patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. And a report in the Journal of Immigrant Health noted that once at the emergency room, they receive far fewer services than do English speaking patients.

For over forty years, civil rights laws have prohibited federally funded entities from discriminating against national origin, racial and ethnic minorities. The U.S. Department of Health and Human Services issued an LEP Guidance that explains the expectations under Title VI of the Civil Rights Act of 1964. This guidance is available at the federal government’s LEP website. The website also includes a Language Access Assessment and Planning Tool that healthcare organizations can utilize to determine the needs of their entities in providing language services.

The National Health Law Program, with support from The Commonwealth Fund, has released three “promising practices” reports that focus on providing language services in healthcare settings. One is titled Providing Language Services in Small Health Care Provider Settings: Examples from the Field and focuses on small provider practices. It offers a suggested plan for providing language services and examples from healthcare providers. Many of these examples, as well as examples from NHeLP’s two other promising practices reports, can be adapted for use in a variety of healthcare organizations.

In 2010, The Joint Commission issued new standards for hospital accreditation that included requirements specifically addressing language services. In conjunction with those new standards, The Joint Commission released Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Care: A Roadmap for Hospitals. This comprehensive guide offers significant resources for healthcare providers both in and out of hospitals on how to provide effective language services. It includes chapters focusing on the steps in the treatment process (admission, assessment, treatment, discharge) as well as a wealth of resources in its appendices.

Additional resources are also available from the federal Office of Minority Health, particularly the Culturally and Linguistically Appropriate Services (CLAS) Standards and the AMA’s Ethical Force Program which offers a toolkit on providing effective communication.

In addition to setting up language services, it is critical that healthcare organizations focus on the competency of those language services. There are significant benefits of working with qualified interpreters. These include a positive impact on risk management, better cost controls, and higher patient compliance and satisfaction.

The Certification Commission for Healthcare Interpreters (CCHI) serves many stakeholders (healthcare providers and insurers, language agencies, government agencies, patients) who need a qualified, certified and competency-based population of healthcare interpreters to ensure effective communication between healthcare providers and insurers and their patients/insureds to ensure access to high-quality healthcare. It also serves the needs of bilingual, spoken-language healthcare interpreters committed to demonstrating their professional knowledge, skills and abilities by becoming certified based on national standards for competency assessment.

The need to provide quality effective language services continues to increase with the changing demographics of the U.S. As noted by a private pediatric practitioner in rural North Carolina, in recent years, the increasing commitment to the LEP population “has been driven less by the necessity to follow federal law than by our realization that these children are part of our future.”
By Elvia Anderson, Call for Health Specialist, NCFH

In many areas of the United States where farmworker families live and work, there are cultural and language differences between health care providers and their farmworker patients. These differences, as well as a lack of understanding of the U.S. health care system, can be a barrier in successfully accessing healthcare services. However, when the life of a loved one is in jeopardy, farmworker families overcome all these barriers. The following account is a good example of this.

In the Hispanic population, most men are not comfortable discussing health issues related to the female reproductive system. Manuel, a young man from Florida, had to overcome this cultural barrier because his sister, April, a 25 year old farmworker, needed surgery. When I asked Manuel what type of surgery his sister needed, he could not comfortably tell me, but timidly said, “She has female problems”. April’s medical records indicated that she was being treated for uterine fibroids.

Because of their limited understanding of the English language and lack of knowledge of the health care system, Manuel and April had agreed to make a deposit of $4000 to the hospital, prior to the surgery, which was something they could not easily afford. The hospital representative was very intimidating and told them that if they did not pay upfront, April would not have the surgery. When they could not gather the money, Manuel started making phone calls to help his sister and then contacted Call for Health for assistance. Call for Health contacted the hospital to see if they had a charity-assistance program. The representative was initially difficult to collaborate with; however, after some negotiation, they accepted a small contribution from the CFH Foundation and agreed to let April have the surgery. The surgeon working on April’s case was kind and offered April a reduced fee for his services, which were paid for in part by contributions from CFH and the Harvest of Hope Foundation. The doctor performed a hysterectomy, successfully treating April’s medical condition.

Two days after the surgery April, not fully recovered, called CFH to ask about the remaining balance due to the hospital and inquired about when she needed to start making payments. I called the hospital and asked if April qualified for any assistance and this time, they did send April’s case to a social worker. Weeks later, I called the hospital billing department and was told that April had been approved for charity assistance and did not owe any money. When I called April and gave her the great news, she was ecstatic. She could not believe it!

April is very young and will not be able to have children of her own; something she wanted very much. “I always dreamed of getting married and having children”, April said the last time we spoke on the phone. With a positive attitude, she added “But right now, I am grateful because Call for Health helped me”. CFH treated her with respect and dignity and showed her compassion when she needed it. It was my pleasure to have met her; she is a kind person that faces adversity with courage. She also has to thank her brother for overcoming the cultural and language challenges he faced.

A Note from the author:
I would like to take this opportunity to thank all the health providers and their staff for their continued dedication to providing quality healthcare services to farmworker families and for respecting and understanding the cultural traditions and beliefs of the farmworker community. With your assistance, Call for Health was able to contribute $9,879.70 in 42 cases. Thanks to the kind collaboration of health providers across the country, we were able to leverage $21,505.93 of in-kind services. In addition, CFH was able to negotiate discounts for existing medical bills and/or lower payment plans for farmworkers. Please remember that the CFH Foundation is able to assist farmworker families through the generous donations from individuals, companies, and corporations. If you would like to donate, please call 1-800-377-9968.

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