The CAHPS Ambulatory Care Improvement Guide

Practical Strategies for Improving Patient Experience

Section 6: Strategies for Improving Patient Experience with Ambulatory Care

6.K. Cultivating Cultural Competence

To download the Guide's other sections, including descriptions of improvement strategies, go to https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html.

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6.K. CULTIVATING CULTURAL COMPETENCE

6.K.1. The Problem

Approximately 21 percent of the U.S. population speaks another language at home, and about 9 percent has limited English proficiency (LEP).[1] Many of these individuals come from racial and ethnic backgrounds that follow different cultural norms and customs related to health and health services. Often these individuals are unable to find information they can understand and use or to get care from providers who speak their native language and/or understand their norms and customs. As a result, when these individuals need services or care, they experience linguistic, cultural, and health literacy barriers that have a negative impact on their experience with care and health care outcomes.[2,3,4,5]

Relevant Questions on the CAHPS Health Plan Survey

Survey questions related to cultural competence are now part of the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) that the Centers for Medicare & Medicaid Services (CMS) is using to assess the performance of health plans offered through the State Health Insurance Marketplaces. This survey expands on the core Health Plan Survey to ask enrollees about –

- Access to interpreters when needed at a doctor's office or clinic.
- The availability of health plan forms in the respondent's preferred language.
- The availability of health plan forms in a needed format, such as large print or braille.

[1] Ryan C. Language use in the United States: 2011. American Community Survey Reports. United States Census Bureau; Aug 2013. Available at: https://www.census.gov/prod/2013pubs/acs-22.pdf.

[2] Ngo-Metzger Q, Sorkin DH, Phillips RS, et al. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med. 2007;22(Suppl 2):324-30.

[3] Weech-Maldonado R, Morales LS, Spritzer K, et al. Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. Health Serv Res Jul 2001;36(3):575-94.

[4] Weech-Maldonado R, Morales LS, Elliott M, et al. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. Health Serv Res 2003 Jun;38(3):789-808.

[5] Weech-Maldonado R, Elliott MN, Morales LS, et al. Health plan effects on patient assessments of Medicaid managed care among racial/ethnic minorities. J Gen Intern Med 2004;19(2):136-45.

6.K.2. Interventions

The variety of strategies available to help health plans reduce linguistic, cultural, and health literacy barriers for their members include the following:

- Maintaining complete and accurate information on enrollees.
- Building a provider network to meet the community's linguistic and cultural needs.
- Training providers on cultural competency.
- Developing linguistically and culturally appropriate educational programs and materials.
- Regularly assessing cultural competence and addressing areas of underperformance.

6.K.2.a. Maintaining Complete and Accurate Information on Enrollees

The first step is to make sure that the organization has accurate and complete information on the race, ethnicity, and language preferences of its members. Having this information allows plan leaders to identify significant gaps between the linguistic and cultural make-up of its members and its provider network and to uncover specific areas where cultural competence may be lacking and/or ethnic and racial minorities are being underserved.

Many health care organizations are required by law to collect information on the race, ethnicity, and language needs of the individuals and populations served or eligible to be served. A handful of states have restrictions on how health plans and other organizations can collect this information. However, these restrictions generally apply to the application process, not to post-enrollment collection of information.

At a minimum, health plans should collect information on race, ethnicity, and preferred language through standard forms filled out by enrollees. These forms should be available in multiple languages and explain why the information is being collected—i.e., to identify and address cultural and linguistic barriers faced by members. Because these standard collection efforts may not yield complete information for all members, health plans can also:

- Pursue more proactive efforts to collect information as part of direct, routine interactions with enrollees.
- Use other sources as well to increase the completeness and accuracy of such information.

An example of a more proactive approach comes from Boston Medical Center's HealthNet Plan, a Medicaid plan that uses both direct and indirect data sources. In

addition to gathering information on race, ethnicity, and preferred language through a health needs assessment filled out by members at enrollment, this plan—

- Trains customer service representatives and care managers to ask members to provide missing information during incoming and outbound telephone calls.
- Collects information from Medicaid application forms.
- Has a software program that uses U.S. census data to assess an individual's likely race and ethnicity based on their last name.

This program led to a significant increase in the proportion of members for whom the plan has this information.[6]

6.K.2.b. Building a Provider Network to Meet the Community's Linguistic and Cultural Needs

Once a plan has complete, accurate information on the race, ethnicity, and language preferences of its enrollees, the next step is to build a provider network that fits a similar profile. As part of the Healthcare Effectiveness Data and Information Set (HEDIS), plans routinely report on the number of practitioners and member services staff providing services to Medicaid and Medicare enrollees in languages other than English. They also track and report the availability of language interpretation services provided to Medicaid and Medicare enrollees.

To go beyond tracking, innovative plans put in place programs to match members with providers who can meet their cultural and linguistic preferences and needs. This approach involves systematically gathering and storing relevant information from providers about their cultural and linguistic profile. For example, CIGNA put in place a program to collect cultural and linguistic information from behavioral health practitioners, including gender, age, race/ethnicity, language(s) spoken, sexual orientation, religion, veteran status, substance abuse recovery status, and disabilities. CIGNA staff use a software system to search this information whenever a member requests a provider with particular characteristics, thus facilitating a cultural and linguistic match between provider and patient. Members of the plan can also search a Web-based directory to help them find practitioners that might be a good match. To make this program work, CIGNA actively recruits behavioral health practitioners that reflect the diversity of the local market (as determined by a review of local market characteristics using census and other data). Specific recruiting goals are set by language(s) spoken, racial/ethnic background, and religion.

[6] AHRQ Health Care Innovations Exchange. Medicaid Health Plan Increases Collection of Race, Ethnicity, and Language Data by Using Direct and Indirect Sources, Including Genealogy Analyses of U.S. Census Data. Agency for Healthcare Research and Quality. July 2014. Available at https://innovations.ahrq.gov/profiles/medicaid-health-plan-increases-collection-race-ethnicity-and-language-data-using-direct-and.

This program led to a significant increase in the number of behavioral health practitioners with cultural backgrounds commonly requested by members, including African Americans (which rose by 80 percent over a five-year period), Spanish speakers (80 percent), and gays/lesbians (68 percent).

Moreover, CIGNA found that its efforts to increase the diversity of its practitioner pool led to higher levels of satisfaction by members on several measures related to cultural competency, including:

- the percentage of respondents who believe that their practitioner meets their cultural, language, and specialty needs;
- the percentage of minority members expressing satisfaction with access to urgent and routine behavioral health care; and
- the percentage of members believing that their provider always/usually listens carefully.[7]

Health plans can also reward providers for contributing to the linguistic diversity of their networks. Kaiser Permanente Southern California, for example, created a Language Concordance Program that offers financial and other incentives for providers to achieve fluency certification in any of 21 designated languages commonly spoken by members. Physicians who already speak the language receive financial bonuses for passing the fluency certification test while those not yet fluent

Health Plan Offers Nurse Advice Line in Spanish

Health plans can also take steps to ensure that their own services address their members' language needs. For example, Molina Healthcare, a Medicaid managed care organization, developed and aggressively marketed a 24-hour bilingual (English and Spanish) nurse advice line to better serve the 45 percent of members who prefer to communicate in Spanish. Eight bilingual registered nurses staff the line, which replaced a traditional advice line where nurses spoke only English. Callers who prefer to speak to someone in a different language can be connected to a separate language line for assistance. The plan also used linguistically appropriate marketing to promote use of the line to Spanish-speaking members.

After Molina introduced its bilingual nurse advice line, calls from Spanish-speaking members increased dramatically, from 2 to 60 percent of all calls.

Source: AHRQ Health Care Innovations Exchange. 24-Hour, Bilingual Nurse Line Provides Advice and Interpreter Services for Plan Members, Leading to Wiser Decisions and Cost Savings. Agency for Healthcare Research and Quality. July 2014. Available at https://innovations.ahrq.gov/profiles/24-hour-bilingual-nurse-line-provides-advice-and-interpreter-services-plan-members-leading.

[7] AHRQ Health Care Innovations Exchange. Insurer's Multifaceted Approach Facilitates Cultural and Linguistic Match Between Patient and Mental Health Provider, Leading to Higher Member Satisfaction. Agency for Healthcare Research and Quality. June 2014. Available at https://innovations.ahrq.gov/profiles/insurers-multifaceted-approach-facilitates-cultural-and-linguistic-match-between-patient.

receive financial support for taking educational classes that help them become fluent. This program increased the number of Spanish-speaking physicians and the proportion of visits where physicians spoke the patient's preferred language (from 24.6 percent in 2008 to 45.0 percent in 2014). It was also associated with improved hypertension control among Spanish-speaking patients.[8]

6.K.2.c. Training Providers on Cultural Competency

Another strategy health plans can use is to sponsor training programs for providers to improve their cultural competency. For example:

- Aetna launched an initiative in 2002 to identify and address health disparities and improve health outcomes for African American and other minority members. Known as *The Racial and Ethnic Equality Initiative*, this program trains Aetna clinical staff and providers on cross-cultural communication (e.g., how to take a patient history, identify cultural issues, and discuss treatment options in a culturally sensitive manner).[9]
- Genesee Health Plan (GHP) partnered with Genesys Health System to develop a health navigator program for low-income residents to help patients adopt healthy behaviors. As part of this initiative, GHP provided cultural sensitivity training to prepare physicians and office staff to care for patients who had been without insurance coverage for many years. Part of the training focused on giving physicians a clear understanding of the social, cultural, and economic barriers this population faces, including multifaceted health needs that in many cases include untreated chronic conditions.[10]

[8] AHRQ Health Care Innovations Exchange. Health Plan's Comprehensive Strategy Involving Physician Incentives and Targeted Recruitment Enhances Patient Access to Language-Concordant Physicians. Agency for Healthcare Research and Quality. August 2014. Available at https://innovations.ahrq.gov/profiles/health-plans-comprehensive-strategy-involving-physician-incentives-and-targeted-recruitment.

[9] AHRQ Health Care Innovations Exchange. Culturally Competent Disease Management Improves Self-Monitoring and Blood Pressure Control in Hypertensive African Americans. Agency for Healthcare Research and Quality. March 2014. Available at https://innovations.ahrq.gov/profiles/culturally-competent-disease-management-improves-self-monitoring-and-blood-pressure-control.

[10] Klein S, McCarthy D. Genesys HealthWorks: Pursuing the Triple Aim Through a Primary Care-Based Delivery System, Integrated Self-Management Support, and Community Partnerships. The Commonwealth Fund. July 2010. Available at http://www.commonwealthfund.org/publications/case-studies/2010/jul/genesys-healthworks.

Resources for Training Providers

- AHRQ Health Literacy Universal Precautions Toolkit, Second Edition. December 2015. Agency for Healthcare Research and Quality, Rockville, MD. Available at http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html. This guide is targeted at physicians, but could be used by plans when working with providers on cultural competence. Tools 9 and 10 deal with addressing language differences and considering culture, customs, and beliefs.
- Quality Interactions: A Patient-Based Approach to Cross-Cultural Care. Available at www.qualityinteractions.com.

6.K.2.d. Developing Linguistically and Culturally Appropriate Educational Programs and Materials

To ensure access to information, most health plans recognize that they need to make basic forms and other commonly distributed written materials available to members in multiple languages. This step is particularly important for marketing materials that inform members of interpretation and other services available to those who speak limited or no English.

To maximize the impact of programs targeted at racial and ethnic minorities, plans can also develop written educational materials tailored to the cultural and linguistic needs of the target population. For example, as part of the Aetna program mentioned above, the health plan distributed written materials developed specifically for African Americans with hypertension. These materials included brochures on nutrition that were designed to be specifically relevant to African Americans, including diet and lifestyle tips that were consistent with the health needs and culture of the target population. One outcome of this program was more frequent self-monitoring and better blood pressure control.[11]

The same kind of culturally tailored approach can also be applied to in-person and virtual classes. For example, HealthPartners (an integrated Minnesota system that includes a large health plan) offers a diabetes outreach and educational program targeted to the large Ethiopian community in its market. Group classes are designed and structured in a culturally sensitive and tailored manner, incorporating elements in line with Ethiopian traditions and beliefs, including integration of a traditional meal, storytelling and visual learning, separate classes for men and women, and breaks for Muslim prayer times. Interpreters versed in predominant Ethiopian languages attend each session to provide translation services. Classes also feature culturally sensitive educational handouts that attendees can take home. This diabetes education program led

[11] AHRQ Health Care Innovations Exchange. Culturally Competent Disease Management Improves Self-Monitoring and Blood Pressure Control in Hypertensive African Americans. Agency for Healthcare Research and Quality. March 2014. Available at https://innovations.ahrq.gov/profiles/culturally-competent-disease-management-improves-self-monitoring-and-blood-pressure-control.

to improved disease control among participants, increased patient engagement, and improved cultural sensitivity among staff.[12]

6.K.2.e. Regularly Assessing Cultural Competence and Addressing Areas of Underperformance

Health plans can conduct regular assessments of how well the plan and its providers are doing in offering culturally competent services. These assessments can be used to identify and address areas of underperformance in a timely and proactive manner.

One potential tool for assessing the cultural competence of providers and identifying what may be driving scores for Provider Communication is the CAHPS Cultural Competence Item Set, which can be added to the CAHPS Clinician & Group Survey.[13] The set includes 34 items that address communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; and experiences leading to trust or distrust. Learn about this supplemental item set at https://cahps.ahrq.gov/surveys-guidance/item-sets/cultural/index.html. Providers and health plans can jointly review the results from this CAHPS item set to identify providers' strengths and weaknesses and choose areas for quality improvement.

Learn More About Conducting a Self-Assessment

- Race Matters: Organizational Self-Assessment. The Annie E. Casey Foundation, Baltimore, MD. Available at http://www.aecf.org/resources/race-matters-organizational-self-assessment/.
- Cultural Competence Checklists. American Speech-Language-Hearing Association. 2010. Available at http://www.asha.org/practice/multicultural/self/.
- An Ethical Force Program™ Consensus Report. Improving Communication—Improving Care. How health care organizations can ensure effective, patient-centered communication with people from diverse populations. American Medical Association, 2006. Available at https://accrualnet.cancer.gov/sites/accrualnet.cancer.gov/files/conversation_files/pcc-consensus-report.pdf. (The Ethical Force Program™ was a collaborative project led by the Institute for Ethics at the American Medical Association.)

[12] AHRQ Health Care Innovations Exchange. Clinics Offer Culturally Tailored Diabetes Education and Culturally Appropriate Care to Ethiopian Patients, Leading to More Engagement, Better Outcomes, and Reduction of Heath Disparities. Agency for Healthcare Research and Quality. January 2014. Available at https://innovations.ahrq.gov/profiles/clinics-offer-culturally-tailored-diabetes-education-and-culturally-appropriate-care.

[13] Ngo-Metzger Q, Telfair J, Sorkin D, et al. Cultural competency and quality of care: Obtaining the patient's perspective. NY: Commonwealth Fund Report; 2006.

6.K.3. Benefits of These Interventions

In addition to contributing to better health outcomes for enrollees, these interventions can generate significant benefits for health plans:

- **Better information and patient-provider matching**. The strategies have led to more complete and accurate collection of enrollee information, along with an enhanced ability to match enrollees with providers who speak their language and understand their health-related cultural norms.
- **Better communication and overall experience**. An enhanced ability to connect enrollees/patients with providers who speak their language and understand their culture-related health beliefs and norms can lead to improvements in patient-provider communication and the overall experience of enrollees/patients. Studies show that—
    - Patients who have access to language-concordant physicians are more likely to report that their concerns and needs were addressed, more likely to bond with their providers, and more likely to highly rate their health care experience.[14,15]
    - Education to provider groups that includes sensitivity training on race, ethnicity, culture, and language improves doctor-patient communication.[16]
    - Having a more diverse workforce that is culturally competent improves enrollee trust in providers and understanding of health plan services and activities.[17]

[14] Ngo-Metzger Q, Sorkin DH, Phillips RS, et al. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med. 2007;22(Suppl 2):324-30.

[15] Fernandez A, Schillinger D, Grumbach K, et al. Physician language ability and cultural competence: an exploratory study of communication with Spanish-speaking patients. J Gen Intern Med. 2004;19(2):167-74.

[16] Wilkins V, Elliott MN, Richardson A, et al. The association between care experiences and parent ratings of care for different racial, ethnic, and language groups in a Medicaid population. Health Serv Res 2011 Jun;46(3):821-39.

[17] Siminoff LA, Graham GC, Gordon NH. Cancer communication patterns and the influence of patient characteristics: disparities in information-giving and affective behaviors. Patient Educ Couns 2006 Sept;62(3):355-60.