A Pediatric Hospital’s Approach to Improving Cultural Competence

Boris Kalanj, MSW, LISW

As discussed in Mutha and Karlner’s article “Improving Cultural Competence: Organizational Strategies for Clinical Care,” it is important to integrate clinical competency into organizational structure. The following article illustrates how one health care organization is approaching building a cultural care strategic plan for reducing health disparities.

Since 1990, Minnesota has experienced a rapid growth in its minority populations. The Twin Cities area has been labeled a “hypergrowth” area for Latino “immigration” (people moving from other parts of the United States) and is home to the largest Somali and Hmong communities in the country [1]. This growing diversity is reflected in the patient profile of Children’s Hospitals and Clinics of Minnesota (“Children’s”). Located in Minneapolis and St. Paul, Children’s is a pediatric health care system consisting of 2 hospitals (319 beds) and several outpatient clinics; it is the largest pediatric health care organization in the Upper Midwest. In 2004, interpretation services were requested for 24,000 encounters, as compared with 7000 in 2000. The most represented language is Spanish (70% of the volume), followed by Somali (15%) and Hmong (8%).

Development of Cultural Care Strategic Plan

In 2001, an interdisciplinary group was charged by the chief operating officer to draft a “cultural care strategic plan.” This initiative was a result of several developments, such as a decade of rapidly changing patient demographics, the publication of federal standards for Culturally and Linguistically Appropriate Services (“CLAS”) in health care [2] and the recent promulgation of the federal OCR guidance on Title VI, an explicit strengthening of the Civil Rights Act of 1964 that guarantees limited English proficiency (LEP) individuals language assistance to ensure “meaningful and equal access” to health care services [3]. Children’s strategic plan was envisioned as a statement emphasizing the importance of building cultural competence as well as an outline of actions to operationalize that effort. The strategic planning group consisted of directors and medical directors of community health and integrative medicine departments, the director of organization development, the communications manager, and the manager of interpreter services.

The planning group was aware of evidence that there is a common tendency among organizations to relegate the responsibility for cultural competence downward or elsewhere. As Lonner concluded in his study of Medicaid managed care systems [4], it is not unusual that the responsibility for cultural competence is delegated to the youngest, least educated, lowest paid, and least supervised staff in the health care delivery system. In response, the strategic planning group was determined to push the cultural competency agenda upward and centrally in the organization.

A cultural care strategic plan was created with 4 concentration areas:

1. Development of Language and Cultural Mediation Services

Concerns related to safety, access, and experience in patient care make the interpreter’s role in bridging communication barriers an immediate priority. The goal of interpreter services has been to create a responsive system that provides qualified medical interpreters whenever and wherever they are needed within Children’s system. As of this writing, Children’s has 12 full-time staff interpreters and employs numerous outside contract and agency interpreters.

In addition to accurately expressing the verbal content of patients’ and providers’ messages, interpreters at Children’s carry out multiple cultural mediation functions. Cultural mediation involves maintaining awareness of verbal and nonverbal cues that indicate implicit cultural content and the potential for culturally-based miscommunication (eg, a display of discomfort when faced with a certain behavior or when certain topics are brought up). When such circumstances occur, staff interpreters assess the situation and intervene to share cultural information they deem relevant and likely to help improve patient care. Staff interpreters have also been encouraged to share observations with the rest of

From the Children’s Hospitals and Clinics of Minnesota, Minneapolis, MN.
the organization. Such feedback is a powerful way for health care organizations to develop sensitivity to disparities.

2. Development of a Culturally Competent Workforce
Beyond knowing how to communicate through medical interpreters, health care workers need to recognize the impact of social and cultural factors on health beliefs, norms, and behaviors and to effectively manage these factors in various interactions with patients. A variety of educational opportunities is regularly offered to all levels of employees, preparing them for effective service delivery in a multicultural health care setting.

3. Creation of Supportive Policies, Procedures, and Management Practices
Efforts to develop a culturally competent workforce would not be effective without the support of organizational policies, procedures, and management practices that enable and encourage employees to practice in culturally competent ways. Children’s human resources department has led an initiative to create a welcoming experience for both patients and staff. The intent is to integrate cultural competence into systems of recruiting/retention, learning and development, and performance measures/rewards, with a goal of creating an organizational culture in which it becomes a norm to strive toward culturally competent practices.

4. Development of Community Partnerships
Strong ties with the community are necessary to anchor a health care organization within its main purpose: serving the community and promoting its health and well-being. Children’s initiatives in community health are particularly strong with minority and LEP groups.

Implementation of Strategic Plan
Children’s has a set of organizational priorities represented by the acronym “S-A-F-E-S-T”—Safety, Access, Finances, Experience, and Strategic Thinking. In building a foundation for the success of the cultural care strategic plan, the planning team explicitly identified how the plan linked to the “S-A-F-E-S-T” themes. Presentations to outline these connections and secure plan buy-in were held early on with the board of directors, executive leadership team, employed physicians group, and directors and managers group. As a result, the executive leadership team added “building cultural competence” as a specific strategy in Children’s operations plan, under “E” (Experience).

Combining Interpreter Services with Education
Health care organizations often approach linguistic and cross-cultural aspects of care as 2 separate entities (eg, a department of interpreter services and a program delivering diversity/cross-cultural competency education). At Children’s, such divisions are seen as counterproductive, as issues of language and culture are most often inextricably linked. Initiatives that combine interpreter services and a cultural competency agenda both address barriers to health care and health disparities, benefit populations that have been underserved, and work to enhance definitions of patient-centered care. Neither area has had a lengthy and well-established presence in health systems. Given these considerations, Children’s strategic plan aims to unify the 2 spheres, led by a belief that they will function best when connected and will strengthen their mutual scope and sphere of influence.

As a result of the strategic plan, Children’s interpreter services was renamed the Department of Cross-Cultural Care and Interpreter Services and was charged with boosting Children’s care of linguistically and culturally diverse patients. At its core, the department is responsible for timely and effective interpreter service as well as for providing cultural competency education for staff and providers. Originally established to only provide language assistance, the department has grown into a broader-focused vehicle for strengthening organization’s service to linguistic and cultural minority patients. Today, it consists of 12 staff interpreters, an interpreter supervisor, 2 schedulers, a cultural care trainer/consultant, an administrative coordinator, and a director. The department has system-wide responsibilities and is overseen by the organization’s chief operating officer.

Cultural Competency Education
Examples of cultural competency education offerings at Children’s include the following:

New employee orientation. Each new employee attends a mandatory 4-hour diversity training session. Opting against “canned” diversity curricula, the session was instead developed as an internal collaboration between the departments of human resources, organization development, cross-cultural care and interpreter services, and an outside community consultant. The curriculum is health care-focused and highly relevant to the specific picture of diversity and features of Children’s pediatric institution. Beyond the “home-grown” design of the curriculum, the planning group also wanted Children’s employees to assume responsibility for delivering the training to new employees. As a result, a “train-the-trainers” program was developed and more than a dozen employees from various departments and backgrounds completed it. The program is now in its third year and is being fully facilitated by internal trainers. In addition to diversity training, every new employee who will have direct contact with patients attends a mandatory 1-hour session on working with interpreters.

Provider education. Beyond new employee orientation,
Children's offers ongoing training in cultural competence to all employees in the organization. This training takes various formats, such as grand rounds, brown-bag lunch discussions, department-specific and profession-specific workshops, ethnic fairs, and self-learning packets. The curriculum varies by audience and is coordinated and delivered by the staff cultural care trainer/consultant. Interpreter services staff members often serve as co-trainers, and on occasion, noted regional and national experts are brought in to present workshops on a particular topic. Such training is sometimes made mandatory for particular audiences. Continuing medical education and continuing education unit credits are offered when possible, which helps motivate attendance at nonmandatory offerings.

The objectives of training for directors, managers, and supervisors are to understand the ramifications of various regulatory requirements, use multiple sources of data to tailor services to patient needs, guide others in providing culturally competent care, gain skills in managing multicultural employees, and direct appropriate responses to patient complaints and grievances. The objectives for clinicians and other care providers center around competencies to elicit an appropriate patient history, perform necessary diagnostic tests, and negotiate medical treatment. Emphasis is placed on learning about the family’s perspective and sociocultural context, examining core cross-cultural issues as they relate to health beliefs and behaviors, developing communication skills for effective work with interpreters, and developing the skills of negotiating in a cross-cultural context [5–7]. A key goal is to overcome "communication autopilot"—our natural tendency as humans to assume that other people share our particular way of perceiving the world. Providers must learn how to "switch off" the communication autopilot, to step outside themselves and try to grasp other perceptual frames of reference, beliefs, values, attitudes, and world views in order to establish a solid healing relationship.

Annual conference. For the past 4 years, Children's has organized an annual conference for the regional pediatric community on language, culture, and health in pediatrics. Participants review research on health disparities, explore culture-specific views on health and health care prevalent in local minority communities, and how those views impact children’s health. Also discussed are strategies for improving communication across languages and cultures as well as ways to resolve ethical dilemmas in care. The conference fee is low for Children’s employees.

Intranet Web site. Another arm of cultural competency education is an internal Web site dedicated to culture, language, and health. Its purpose is to emphasize the synergy between culture, health, and health care delivery while providing an interactive forum for sharing questions, offering advice, and showcasing best practices in the delivery of culturally competent care.

Integrating the CLAS Standards into Patient Care Plans
To promote cultural competency at the bedside, a new prompt was added to the computerized “plan of care,” a mandatory nursing activity with each new inpatient: CLAS (Culturally and Linguistically Appropriate Service). The screen prompts nursing staff to consider the following interventions: consulting appropriate cultural resources (eg, Children’s cross-cultural care and interpreter services department, ethnic healers, and community leaders), arranging for in-person interpreter services and using phone interpreting while waiting for their arrival, and utilizing available translated patient education materials.

Centralized Interpreter Scheduling
Children’s has centralized interpreter scheduling via a dedicated call center, which is used 24 hours a day, 7 days a week. During the day hours, the line is staffed by 2 “live” schedulers. During evenings and weekends, callers are prompted by the phone system to select the language that they need and then immediately connected to a cell phone held by an on-call staffing interpreter for Hmong, Somali, or Spanish. For all other languages, the caller is connected to an outside contracted agency. Access to a national telephonic interpreting service is integrated into the phone system as the ultimate back-up option.

After about 15 months of planning, interpreter scheduling has been integrated into Children’s main computerized patient scheduling system. This has given us the ability to track data and review utilization patterns, thus increasing efficiency in deploying interpreters. In addition to phone requests, requests can now be submitted to interpreter schedulers electronically (via print queues from patient registration screens) by staff in requesting units/department.

Written Materials
Written translations are another important feature of a culturally competent health care organization. The goal is to ensure that written materials routinely provided in English—especially those related to making educated decisions about health care—are available in commonly encountered other languages [3]. Examples of relevant material include notices of interpreter availability, intake forms, consent forms, treatment instructions, discharge instructions, the Patient Bill of Rights, privacy notices, and a variety of patient education materials.

Among other translations at Children’s, to date hundreds of pediatric patient education sheets on topics ranging from asthma to wound care have been translated by Children’s staff interpreters into Hmong, Somali, and Spanish. These
are available for public use on Children’s Web site (www.
childrenshc.org). Of note is also a regional initiative called
the “Multilingual Health Resources Exchange,” for which
Children’s served as a founding member. The Exchange is
consortium of health care organizations and health plans
aimed at sharing translated and multilingual materials rele-
vant to patient care. Materials developed and shared by
member organizations are housed on a Web database and
and commitment in asking these questions.

Patient Experience and Satisfaction
In 2004, the organization went through a process of chang-
ing vendors for patient satisfaction/experience surveys. The
selection process included, among other criteria, an exami-
nation of the capacity of each vendor to gain insight into
families’ perception of the cultural competence of Children’s
staff. Upon selecting the vendor that best met its selection
criteria, Children’s adapted their standard questionnaire
to enable an even stronger inquiry into diversity and cultural
competence perceptions. The following is an example of an
added question: “During your stay at Children’s, do you feel
you were treated differently from other families based on
your race, ethnicity, culture, religion, or primary language?”
Responses covered a 5-point Likert scale from “often better
than others” to “often worse than others.”

Cultural Competency Evaluation
As an example of cultural competency evaluation, under the
project name “Partnership for Peds,” one of Children’s general
pediatric clinics examined its service delivery to minority pa-
ents and implemented significant changes based on the find-
ings. The study involved focus groups with patients and semi-
structured individual interviews with clinic staff. It sought to
understand the needs of Somali, Latino, and African American
patients, identify barriers to health care, and assess the clinic’s
staff cultural competency. The study uncovered a gap between
families’ and staff’s perceptions of the families’ needs, prefer-
ences, and barriers to care, which indicated a need for stronger
cultural competency staff education. It also revealed a high
level of inappropriate emergency department utilization,
which highlighted a need for educating LEP families on the
specifics of clinic operations and, in general, the features of the
American health care system. As a result, 2 interpreters/
cultural mediators were hired and dedicated solely to working
in the clinic. They were given an expanded role to include
delivery of an educational curriculum to families and cultural
competency in-services to clinic staff. As of this writing, a re-
search study is underway to evaluate the effectiveness of this
educational intervention by measuring retention of knowl-
edge, as well as any changes in the rates of utilization of the
emergency department for nonurgent matters.

Conclusion
Improving cultural competence at a large pediatric institu-
tion is an ongoing, multifaceted effort. The results are likely
to be the strongest when this effort is fully integrated with
the organization’s strategic priorities and when all major as-
psects of the organization’s functioning are purposefully in-
cluded. Cultural competence is not something that can be
fully achieved but is a continual process of finding out, lis-
tening, and opening up to the greater community in which
health care functions. Many of the programs described in
this article could be initiated and adapted by other health
care institutions; it is important, however, to tailor efforts to
the specific demographic and institutional context in which
each organization operates.

Corresponding author: Boris Kalanj, MSW, LISW, 2525 Chicago Ave.
South, Minneapolis, MN 55404, boris.kalanj@childrensmn.org.

References

1. Ronnigen BJ. Who is here in Minnesota? Minnesota State
Demographic Center. Presentation at the September 25, 2002
meeting of the Minnesota Immigrant Health Task Force; 2003.
2. Office for Civil Rights. Guidance to federal financial assistance
recipients regarding Title VI Prohibition against national origin
discrimination affecting limited English proficient persons.
3. Pacheco G, Jacobs CG. National standards for culturally and
linguistically appropriate services in health care [abstract].
U.S. Dept of Health and Human Services, Office of Minority
Health. Presented at the 129th Annual Meeting of American
Public Health Association (APHA); 2001 Oct 21–25; Atlanta,
GA. Available at http://apha.confex.com/apha/129am/
4. Lonner TD. Constructing the middle ground: cultural com-
petence in medicaid managed care. Seattle (WA): The Cross
Cultural Health Care Program; 2000.
5. Kleinman A, Eisenberg L, Good B. Culture, illness, and care:
clinical lessons from anthropologic and cross-cultural re-
6. Tervalon M, Murray-Garcia J. Cultural humility versus cultur-
al competence: a critical distinction in defining physician train-
ing outcomes in multicultural education [editorial]. J Health
7. Betancourt JR. Cross-cultural medical education: conceptual
approaches and frameworks for evaluation. Acad Med 2003;
78:560–9.
8. Joint Commission on Accreditation of Healthcare Organiza-
tions. JCAHOnline: May 2005. Available at www.jcaho.org/
about+us/news+letters/jcahonline/jo_05_05.htm. Accessed
16 Dec 2005.

Copyright 2006 by Turner White Communications Inc., Wayne, PA. All rights reserved.