Implementing Multicultural Health Care Standards:

Ideas and Examples

NCQA
20 YEARS
Measuring quality.
Improving health care.

Implementing Multicultural Health Care Standards:
Ideas and Examples

The NCQA Multicultural Health Care (MHC) standards were developed from other consensus-based standards, including those from the federal Office of Minority Health (OMH)[1] and the National Quality Forum (NQF);[2] recommendations from the Institute of Medicine (IOM) Subcommittee on Data Standardization;[3] federal and state regulations; and research evidence that supports the feasibility of the requirements of each standard. Ideas and examples in this report are organized according to the MHC Distinction product. Examples are drawn from applicants to the NCQA Recognizing Innovation in Multicultural Health Care Awards Program. Additional examples and resources are available in NCQA's Innovative Practice Reports, issued annually from 2006–2009, available at http://www.ncqa.org/clas.aspx and Multicultural Health Care: A Quality Improvement Guide, available at www.clashealth.org.

From 2006–2009, health plans submitted applications to the NCQA Recognizing Innovation in Multicultural Health Care Awards Program, highlighting their activities as they sought to improve culturally and linguistically appropriate services (CLAS) and reduce disparities in care. We hope this report stimulates ideas for implementation of the standards.

1 Race/Ethnicity and Language Data

THIS STANDARD REQUIRES ORGANIZATIONS TO COLLECT INFORMATION that helps them understand the composition of the population, provide culturally and linguistically appropriate services and detect health care disparities. The first step is to collect race/ethnicity and language needs data directly from individuals and indirectly, using estimation methods. Although individuals are not required to report their race/ethnicity and language, the organization must attempt to collect this information from them. This standard specifies elements pertaining to collection of race/ethnicity and language, privacy protections for such data and notification of privacy protections.

BACKGROUND

Several consensus-based standards contributed to the development of this standard: the IOM (2009) report outlining evidence and recommendations for the collection of race/ethnicity and language data;[3] the OMH CLAS Standards[1] which recommend federal and state agencies and national accrediting bodies require health care organizations to collect and use patient/consumer race/ethnicity and language data; and Joint Commission's current Hospital Accreditation Standards[4] which include information on cultural competency for staff as well the collection of race/ethnicity data in the medical record; the Joint Commissions' 2009 proposed Hospital Accreditation Standards[5] which include requirements to collect race, ethnicity, language, and religion data; the NQF consensus report outlining preferred practices in this area; and the NQF-endorsed Health Research and Educational Trust (HRET) Toolkit, which contains suggestions for collecting the data in the hospital setting.[6]

Some federal requirements specifically address collection of race/ethnicity data:

- Title VI of the Civil Rights Act of 1964 provides a legal foundation for collecting racial and ethnic data by health care providers that receive federal funds.[7,8,9]

- For HHS programs that provide health care services, three statutes explicitly require collection or reporting of racial and ethnic data and two require collecting "demographic" information or enrollee "characteristics."[10]

- Federal regulations require that states provide Medicaid MCOs and health plans with the race, ethnicity and primary language of enrollees.[10]

Six states (California, Maryland, New Hampshire, New Jersey, New York, Pennsylvania) have laws or regulations restricting a health plan's collection of data on race and ethnicity; these restrictions apply only to the collection of data during the application process and only apply to state-regulated insurance or self-insured ERISA-governed employer-sponsored health plans, as preempted by federal law. Four states (California, Maryland, New Jersey, Texas) explicitly require, encourage or allow race and ethnicity data to be collected, depending on the process used or the health insurance product. Other states (Massachusetts, Minnesota) do not statutorily mandate that health insurance plans collect such data, but encourage or require it through other state vehicles.[11]

DIRECT DATA COLLECTION

The Institute of Medicine recommends direct collection of race/ethnicity and language data.[3] Organizations or organization staff must collect race/ethnicity and language data directly from eligible individuals. Health plans, hospitals and other providers can use the HRET Web-based Toolkit as a guide for collecting race/ethnicity and language information from patients that meets regulatory and local community needs.[6] A national survey of adults found that over 50 percent of respondents favor legislation allowing race/ethnicity data collection when told of its benefits.[12] Another study found that patients felt most comfortable providing the information when they were told that it would be used to "monitor care to ensure that all patients get the best care possible."[13]

Many organizations have shown they can successfully collect data on race/ethnicity and language and use the data to reduce health care disparities.

Health plans and other organizations have shown that they can successfully implement comprehensive, direct data collection efforts and then use the data to develop successful programs to address health care disparities. Such programs more effectively target populations and allow more accurate pre- and post-intervention data collection and measurement.

Some considerations for data collection are:

- Use standard response options for questions about race/ethnicity and language.

- Use a consistent approach to roll-up more detailed race/ethnicity or language information to the Office of Management and Budget (OMB) categories.

- Develop a standardized approach to prioritizing conflicting data about an individual, obtained from different sources or at different times.

- Document refusal to provide information and notify staff so that individuals are not asked for the information repeatedly. This can be done automatically in electronic systems; in paper systems, another notification system can be devised.

- Develop strict policies to protect the data against inappropriate use and disclosure. For example, "Race/ethnicity and language data may not be used to offer or decline medical services to eligible individuals or to any particular group."

There are challenges to direct data collection. Some race/ethnicity or linguistic groups might not be listed in categories collected on surveys and forms, especially if an organization does not yet collect detailed ethnicity and language categories. In this case, the organization must offer an "Other" category.

EXAMPLES OF IMPLEMENTATION

Organizations can use different methods to address this standard.

• Use multiple opportunities to collect data, including from all direct points of contact between the organization and eligible individuals (e.g., enrollment, online portals or health risk assessments when not prohibited by state law, information collected when eligible individuals speak with customer service or patient management representatives).

• Use paper and electronic forms to collect race/ethnicity and language information.

• Provide training and ongoing education that explains the purpose and emphasizes the importance of collecting these data. Train all staff who interact with eligible individuals, including customer service representatives, claims staff, wellness coaches, disease management nurses, case managers and care coordinators, and, where applicable, appointment schedulers, medical office assistants, nurses and doctors in provider offices.

• Provide scripts for staff to use when asking about race/ethnicity and language. The scripts should explain how the data will (and will not) be used. Research shows that patients are more willing to divulge race/ethnicity and language information when they know how it will be used.[13]

Take advantage of all opportunities to collect data directly, including at all points of contact, and supplement these with indirect methods.

INDIRECT DATA ESTIMATION AND OTHER DATA SOURCES

Although direct data collection is considered the most accurate method of data collection, direct data collection usually will not result in a complete set of information for the organization's eligible individuals. Unless organizations have direct data on at least 80% of their eligible individuals, they must use indirect data estimation methods (e.g., geo-coding and surname analyses) in conjunction with direct data collection methods.[14,15] Many organizations work with technical experts who specialize in indirect data collection and who have the software to do so accurately.

While the primary use of indirect data estimation is to supplement data that cannot be collected directly, organizations also use indirectly estimated race/ethnicity and language data to:

• Examine differences between racial/ethnic and language groups on various health indicators.

• Examine member and provider geographic dispersion by loading race/ethnicity and quality metric data into Geographic Information Systems (GIS) software, a tool used to map demographic information. This information is useful in developing targeted QI programs for specific populations and neighborhoods.

• Develop culturally appropriate materials and programs.

• Develop linguistically appropriate materials and language services.

Other sources of racial/ethnic and language data are CMS data, for Medicare populations; state Medicaid eligibility files, for Medicaid populations; and state, school district or census data.

2 Access and Availability of Language Services

THIS STANDARD REQUIRES ORGANIZATIONS TO PROVIDE WRITTEN and spoken language services to eligible individuals, to notify them of the availability of such services and to help the practitioner network provide these services to eligible individuals at the point of care. The elements specify that there should be a mechanism to evaluate the quality of these services. Practitioners should be offered training on language services, in addition to having access to data on the language needs of the patient, the organization and the community. Organization employees can be assessed for language proficiency before they are used as bilingual communicators.

BACKGROUND

A 2003 IOM report, *Findings and Recommendations on Health Disparities*, states that existing policy supports the use of interpretation services where community need exists. OMH recommends[1] that language assistance services be offered to eligible individuals in their preferred language. The NQF consensus[2] and Joint Commission reports outlined preferred practices that promote language access for eligible individuals.[4,5]

Title VI of the Civil Rights Act of 1964 states that "no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[8] This legislation requires that any program or organization that receives federal funds of any amount, directly or indirectly, and for any reason must, among other duties, deliver services regardless of the language of the recipient of a program or organization. DHHS issued guidance in 2000 and updated it in 2003, which clarified that Title VI requires federal funds recipients to provide translation services for people who do not read English when "reasonable," as defined by specified thresholds.[9,16]

Studies show that language barriers have a demonstrated negative effect on communication, satisfaction and appropriate health care utilization. Limited English proficient (LEP) patients who need an interpreter, but who do not receive an interpreter or who instead depend on an ad hoc interpreter such as a family member, are less likely to be satisfied with their care than LEP patients who see a bilingual provider. Such LEP patients are also less satisfied than English-proficient patients seen by an English-proficient provider.[17,18]

A growing body of literature suggests that language assistance interventions, such as oral interpretation, improve patient experiences and comprehension and can improve appropriate health care utilization. Examples of such improvements include an increase in the amount of time doctors spend with patients, a reduction in diagnostic testing disparities among English-speaking patients versus LEP patients, higher clinic return rates and increases in primary care services utilization.[19] Studies report positive benefits of professional interpreters on communication (errors and comprehension), utilization, clinical outcomes and patient experiences with care.[20] The use of professional interpreters is associated with more improved clinical care than use of ad hoc interpreters, and professional

interpreters appear to raise the quality of clinical care for LEP patients to approach or equal that of patients without language barriers.[20] Studies show that LEP patients with interpreter services have more physician office visits and prescriptions, use more preventive services and rate care better than comparable patients without interpreters.[21,22,23,24] Interpreter services have been found to lower costs by decreasing the use of diagnostic testing, and reducing the probability of hospital admission, receipt of intravenous fluids and post-emergency department (ED) visit charges.[25]

Although no single standard has yet emerged for assessing the competence or effectiveness of health care interpreters, there are several efforts underway to certify health care interpreters.[26,27,28] These efforts are supported by a body of research that indicates that among others, communication and care satisfaction are better and there is a higher use of outpatient care and prescription filling when LEP patients use trained, professional interpreters instead of ad-hoc interpreters.[29]

EXAMPLES OF IMPLEMENTATION

Organizations can use different methods to address this standard.

- Educate practitioners and staff about the needs and rights of LEP individuals to access language services.

- Provide Web sites and written materials in multiple languages, especially in those most prevalent in the eligible population.

- Include information about language services on Web sites and newsletters.

- Offer handouts and fliers at practitioner offices, with information on accessing language services through the practitioner network or the organization.

- Standardize the process of translating written materials and include steps to validate the resulting translations when they are performed in-house. The translation process might include:

  ○ Evaluation of English material for literacy level and cultural inclusion

  ○ Development of a style guide for use by translators

  ○ A screening process for translation vendors that focuses on quality processes

  ○ Development of language glossaries that standardize terms used by translators

  ○ A translation review process to ensure that translated materials are the same quality as the English source document.

- Use a standard assessment tool to determine linguistic proficiency of organization staff who have contact with eligible individuals.

- Use different staff with varying levels of language proficiency to communicate with LEP eligible individuals at different levels of contact and complexity. In one such program already in use, staff language capacity is evaluated and individuals with differing levels of competency handle varying levels of complex tasks, from scheduling appointments and providing non-medical instructions, to performing sight translation of documents in English in moderately complex clinical encounters.[30]

- Collaborate with local colleges or organizations for ongoing education of staff, practitioners and medical interpreters.

> A growing body of literature suggests that professional language services, such as oral interpretation, can improve patient experiences and comprehension, and can improve clinical care.

OTHER KEY THEMES

Language services must be designed as sustainable. Unless there is leadership commitment to substantial funding for hiring new staff or adopting new resources, such as a telephone interpreter service or translation service, many language access programs are at risk of failing when their demonstration or trial period ends.

Many organizations make their language access programs sustainable by training existing staff. Some organizations, especially staff or group model health plans, verify or certify practitioner and staff foreign language skills. One plan created their own assessment to evaluate the physicians on many CLAS related proficiencies, such as fluency and pronunciation of language and customer service and cultural proficiency. The main focus of this assessment was to assess the physician's 'communicative competence' which is "the ability to meaningfully and accurately understand and produce the target language in a medical setting in a culturally appropriate way."[31]

More often, staff are taught when and how to provide written or audiovisual materials developed in a different language. Training includes directing eligible individuals to a bilingual staff member or interpreter or to a contracted language service provider, such as a language line.

3

Practitioner Network
Cultural Responsiveness

THIS STANDARD APPLIES ONLY TO ORGANIZATIONS that are responsible for forming a practitioner network. The

standard requires the organization to maintain a practitioner network that can meet the cultural and linguistic needs of

its eligible individuals. Elements specify that the organization should collect and share practitioner race, ethnicity and

language data, and that the organization should regularly assess the network's capability to provide linguistically and

culturally appropriate care, and address shortcomings when necessary.

BACKGROUND

The OMH CLAS standards have three provisions that require organizations to provide CLAS:

Health care organizations should

1. "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;

2. 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; and

3. ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery."[1]

The NQF Consensus Report outlined nine preferred practices that promote cultural competency in health care delivery settings at the leadership level, at the patient-practitioner communication level and in workforce diversity and training.[2] Additionally, the American Medical Association, the Association of American

Medical Colleges and other medical associations have developed toolkits and training curricula, as well as provided cultural competency training programs for medical students, residents in training and physicians in practice.[32,33]

Studies show that the physician-patient relationship is strengthened, leading to higher feelings of trust, satisfaction and adherence to treatment when patients feel that their beliefs, values and communication are similar to their health care provider. Factors such as similar perceived race usually lead a patient to feel ethnically similar to their physician while a physician's use of patient-centered communication leads to a patient's belief in perceived personal similarities.[34]

Anecdotal evidence suggests that lack of diversity in the leadership and workforce of health care organizations results in structural policies and delivery systems that are inappropriately designed or poorly suited to serve diverse patient populations.[35,36,37] Conversely, paying attention to language needs, various religious taboos, explanatory models of disease and alternative remedies may lead to better care.[38]

EXAMPLES OF IMPLEMENTATION

Organizations can use different methods to address this standard.

• Post language information about a practitioner's office staff on a Web site or provider directory.

• Provide language and cultural competence training to practitioners and staff, with emphasis on how to access and use language services.

• Hire or contract with community health workers who are aligned with eligible individuals linguistically and culturally.

• Provide language resources on Web site so practitioners can provide materials to patients in their preferred language.

• Assist eligible individuals to find practitioners who speak their preferred language.

• Recruit bilingual staff as needed to meet patient demand.

Another key aspect to developing a sustainable program for supporting racial and ethnic minorities is to create and implement resources for training staff. As noted above, some organizations assess and certify the language and translations skills of practitioners, while other organizations have created training programs to educated staff on cultural sensitivity and communication skills.[39] Many organizations are making a concerted effort to hire additional staff and recruit practitioners to meet the cultural and linguistic needs of their eligible individuals.

Studies show that the physician-patient relationship is strengthened, leading to higher feelings of trust, satisfaction and adherence to treatment when patients feel that their beliefs, values and communication are similar to their health care provider.
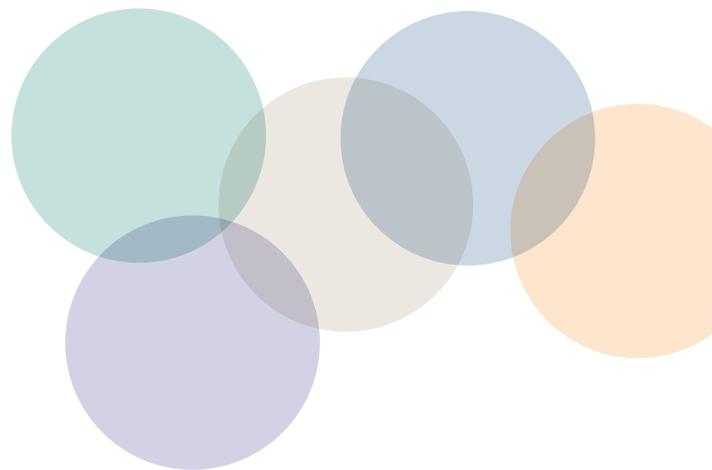
4 Culturally and Linguistically Appropriate Services Program

THIS STANDARD REQUIRES ORGANIZATIONS TO DEVELOP a written plan including measurable goals, and annually evaluate their programs to meet the needs of a culturally and linguistically diverse population. Elements specify that community members should be involved in designing and evaluating the programs, and that there is ongoing analysis of evaluation results.

BACKGROUND

The OMH CLAS Standards[1] recommend that organizations develop a written strategic plan for the provision of CLAS and develop participatory, collaborative partnerships with communities, using a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities. The NQF 2009 Consensus Report[2] outlines preferred practices related to community engagement. These include collaborating with communities to identify changing needs of patient populations and gaps in health care, as well as implementing health disparity programs and evaluating the effectiveness of cultural competency programs.

EXAMPLES OF IMPLEMENTATION

Assessment methods depend on the activity. For example, outreach to minority populations for preventive screenings and vaccinations may aim to increase clinical performance scores for HEDIS®[40] and patient experiences results for CAHPS®.[41] While some organizations specify how many percentage points they want to improve in a specific period, others take a less-structured approach. Other initiatives, such as language access programs, rely on user surveys to measure feedback on the programs' effect. Still other programs collect data on the use of tools, such as Web sites or multi-lingual customer service hotlines. Some programs may collect intermediate outcome data, such as the frequency of matching practitioners and patients with the same language.

COLLABORATION WITH COMMUNITIES & EXTERNAL ORGANIZATIONS

Many initiatives require a strong partnership with the community and its leaders to get off the ground. Some organizations develop a trusting relationship with the community by establishing themselves as supporters of its health and well being, through their own initiatives and by supporting other community programs. Including and involving respected community leaders in planning, implementing and evaluating programs is also important.

As noted above, many organizations rely on HEDIS and CAHPS performance data to identify health disparities in eligible populations and to measure the effectiveness of their interventions. For these programs and interventions to be most effective and relevant to their target populations, organizations need to involve community members in their design and evaluation.

Some organizations locate CLAS programs in community centers and clinics in the heart of underserved communities or in locations where minority populations tend to be concentrated. Developing and maintaining relationships with such clinics is important for implementation in

populations that may not have easy access to health care. Initiatives aimed at reducing health care disparities have been implemented in churches, gyms, barbershops, hair and nail salons, local grocery stores and public schools. Some organizations rely on volunteer social workers, trained community health workers and local academic partners to implement programs in community settings. Volunteers go into the community to inform people about new initiatives at the regular clinics, or take health education to the community setting. These outreach activities may include, but must not be limited to, community health fairs.

Other venues for disseminating information are the Internet, radio, television, ethnic newsletters and local newspapers. Some health plans have established storefront centers located in the heart of various hard-to-reach communities, staffed by bilingual and bicultural employees who can help clients with everything from enrollment in a health plan, to health education and enrollment in a variety of social services.

Organizations also perform additional research with eligible individuals, or in the community or population of interest, as they design a new program. A common method of involving community members is through focus groups. In one organization, minority members participated in focus groups to develop training modules (e.g., PowerPoint presentations and written materials) for staff to use with ethnic minority groups. The organization cited these training materials as a key step in developing a sustainable program.

Members of the community or the population of interest can also work on a program's design and evaluation committee. For example, a health plan that served a low-literacy population learned from its patients that visual materials about preventive screenings would be more useful than written materials. The plan developed materials in video format and gave practitioners scripts that included data on disease prevalence in specific racial and ethnic groups, so recommendations could be customized.

Organizations have also found success collaborating with other health care organizations in the community: local and state departments of health, hospitals, clinics, health plans and programs such as WIC and Head Start. Partnerships such as these can also help with pooling and sharing specialized resources needed to serve the community.

EXAMPLES OF IMPLEMENTATION

Organizations can use different methods to address this standard.

- Use well-known cultural icons and celebrities to draw community interest and participation.
- Work with churches and community centers to develop and implement programs tailored to the community.
- Offer incentives, such as gift cards and certificates, for participating in initiatives or completing screenings, vaccinations or well-child visits.
- Use focus groups or surveys to identify specific local, regional or other barriers to screenings, vaccinations or other preventive care.
- Use focus groups to pilot test culturally and linguistically appropriate educational materials or communication campaigns.
- Involve community and religious leaders to ensure successful dissemination of information to a targeted audience.

Programs to improve CLAS should involve members of the community in their design and evaluation.

5 Reducing Health Care Disparities

THIS STANDARD REQUIRES ORGANIZATIONS TO USE DATA to assess the presence of disparities, undertake quality improvement efforts to decrease or eliminate them and improve culturally and linguistically appropriate care. Elements specify that the organization should stratify performance measures by race/ethnicity and language; monitor use of, and experience with, language services; and undertake quality improvement projects to address disparities or other opportunities to improve CLAS.

BACKGROUND

The OMH CLAS Standards[1] include two standards encouraging assessment of CLAS programs:

1. "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" CLAS.

2. "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."

The NQF Consensus Report[2] outlines preferred practices regarding leadership, integration into management systems and data collection for quality improvement. These involve creating and sustaining an environment of cultural competence through structures, systems, written policies, practices, procedures and programs, as well as marketing culturally competent services to the community. The NQF also recommends applying a quality improvement framework to cultural competency and making regular announcements to the public about the progress of successful cultural competency innovations.

CMS requires its managed care plans to engage in ongoing quality improvement efforts. In addition, CMS contracts with Quality Improvement Organizations (QIO) in each state to "improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries" by implementing programs to improve quality and efficiency of care, among other things.[42] Every year CMS announces a concentration for the QIOs to address in their work for the following three years. The eighth scope of work (beginning in 2005) for the QIOs included a focus on disparities reduction.[43] The ninth scope of work (beginning in 2008) was billed as a more comprehensive view of care between many silos compared to previous scopes of work; one theme, prevention, had a specific focus on reducing disparities for Medicare beneficiaries with diabetes.[44]

Some state laws and Medicaid contracts require health plans to conduct a self-assessment, evaluation or quality improvement project on cultural or linguistic issues or health care disparities.

TABLE 1 State CLAS Requirements

STATE	LAW, REGULATION OR CONTRACT PROVISION
CALIFORNIA	SB 853: Requires MCOs and insurance plans to provide language services and report to the legislature annually on several cultural competency measures. Medi-Cal (Medicaid) managed care program includes development of a cultural and linguistic services plan with activities, time lines and milestones; identification of responsible individuals (including organization charts, types and responsibilities of staff); development and implementation of standards and performance requirements; performance monitoring; and protocols for appointment scheduling and system coordination.
CONNECTICUT	An MCO or hospital may develop community benefit guidelines to promote preventive care and improve the health status for working families and populations at risk, whether or not they are enrollees of the managed care plan or patients of the hospital. Guidelines focus on developing a program based on an assessment of health care needs and resources of the targeted populations, particularly barriers to accessing health care, including cultural and linguistic barriers to care.
KENTUCKY	(Medicaid) Health plans are required to establish a QI program that continually evaluates access, continuity of care, health care outcomes and provided or arranged services to members. Plans must base evaluation of the program on information about the population served and address services and health care outcomes of all subpopulations, including member category of Medicaid, type of disability and chronic illness, race, ethnicity, gender and age.
NEW MEXICO	(Medicaid) The Medicaid quality management program description or work plan addresses activities focused on culture-specific health beliefs and behaviors, as well as risk conditions, and responds to member and provider requests for culturally appropriate services.

Create and sustain an environment of cultural competence through structures, policies and continuous quality improvement using data on race/ethnicity and language.

EXAMPLES OF IMPLEMENTATION

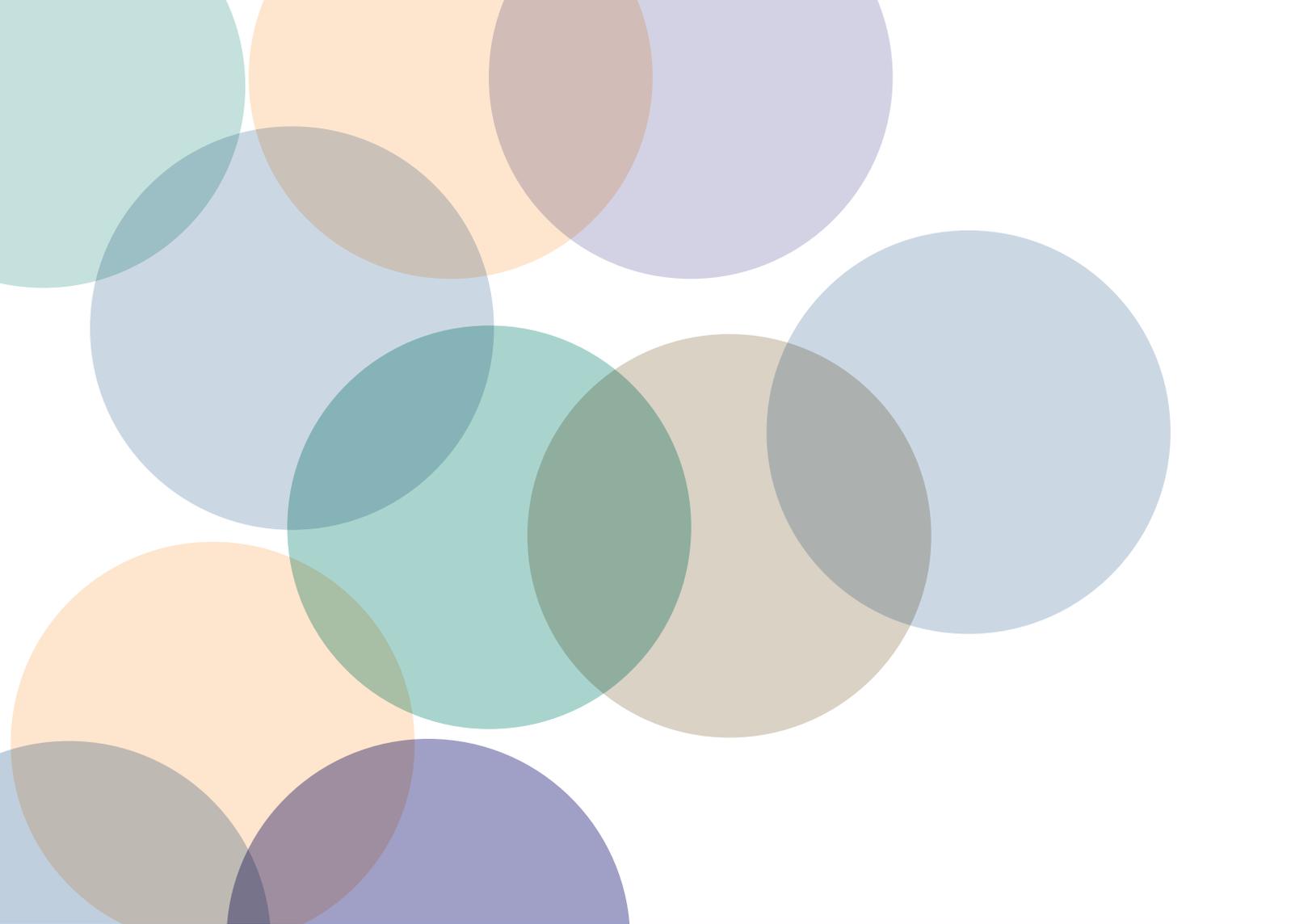Organizations have used different methods to address this standard.

• Developed a comprehensive bilingual Web site to better equip health care practitioners with culturally appropriate health education materials, in response to a community survey indicating that 90 percent of individuals preferred to receive written materials in their ethnic language.[30]

• Used games and physical activity as a platform to address the high rate of asthma in the community. One organization's initiative included asthma screenings, family education, full physicals, medication review and an individualized action plan to increase appropriate use of preventive medications, reduce ER visits and hospital admissions.[30]

• Developed a culturally and linguistically appropriate program of preventive care for women, based on data showing at least 25 percent of the female population in the community is of foreign descent. Program goals are to develop a culturally sensitive environment for preventive care services and linguistically appropriate materials to remove language barriers for women. Four-year trend data show significant increase in the rate of prenatal and postnatal care, and cervical cancer and Chlamydia screenings.[39]

References

1 The Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* March 2001.

2 The National Quality Forum. *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report.* May 2009.

3 Institute of Medicine of the National Academy of Sciences. *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement.* 2009. Available at: http://www.nap.edu/catalog/12696.html

4 The Joint Commission. *The Joint Commission Standards Supporting Effective Communication, Cultural Competence, and Patient-Centered Care.* 2009. http://www.jointcommission.org/NR/rdonlyres/ B48B39E3-107D-495A-9032-24C3EBD96176/0/ PDF32009HAPSupportingStds.pdf

5 The Joint Commission. *Proposed Requirements to Advance Effective Communication, Cultural Competence, and Patient-Centered Care for the Hospital Accreditation Program.* 2009. (Currently under revision) http://www.jointcommission.org/NR/ rdonlyres/D44C4DE4-F5CD-4116-84AF-D5B3E8D4E94F/0/ PDF1HAPProposedRequirements.pdf

6 Hasnain-Wynia R, Pierce D, Haque A, Hedges Greising C, Prince V, Reiter J. (2007) *Health Research and Educational Trust Disparities Toolkit.* hretdisparities.org accessed on 3/12/10.

7 Rosenbaum S JD, et al. *Policy Brief: The Legality of Collecting and Disclosing Patient Race and Ethnicity Data.* The George Washington University School of Public Health and Health Services Department of Health Policy. June 2006. http://www.rwjf.org/files/publications/other/ RaceEthnicDisparitiesData06222006.pdf

8 DiversityRx. Title VI of the Civil Rights Act of 1964. http://www.diversityrx.org/html/LELAWS.htm Updated March 2003.

9 U.S. Department of Health and Human Services. "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons." http://www.hhs.gov/ocr/ civilrights/resources/specialtopics/lep/policyguidancedocument.html

10 Perot Ruth T and Youdelman Mara. "Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices." *The Commonwealth Fund*, September 2001.

11 America's Health Insurance Plans. *Tools to Address Disparities in Health: Data as Building Blocks for Change.* http://www.vdh.virginia.gov/ohpp/clasact/documents/CLASact/ research/default.pdf. Updated May 2005.

12 Robert Wood Johnson Foundation. "Key Findings of a National Survey Conducted among Adults Who Have Health Care Coverage on Behalf of RWJF on the Issue of Disparities in Healthcare." 2003. Available at http://www.rwjf.org/files/newsroom/POSfullMemo.pdf

13 Baker DW, Cameron KA, Feinglass J, Georgas P, Foster S, Pierce D, Thompson J, and Hasnain-Wynia R. "Patients' Attitudes Toward Health Care Providers Collecting Information About Their Race And Ethnicity." *Journal of General Internal Medicine* Vol 20 (10). October 2005.

14 Elliott MN, Fremont Allen Peter, Morrison A, Pantoja Philip, and Lurie Nicole. "A New Method for Estimating Race/Ethnicity and Associated Disparities Where Administrative Records Lack Self-Reported Race/Ethnicity." *Health Services Research.* Volume 43, Issue 5p1, Pages 1722–1736.

15 Fiscella K and Fremont AM. "Use of Geocoding and Surname Analysis to Estimate Race and Ethnicity." *Health Services Research* 41:4, Part I (August 2006).

16 Au M, et al. "Improving Access to Language Services in Health Care: A Look at National and State Efforts." *Mathematica.* April 2009.

17 Lee LJ, et al. "Effect of Spanish Interpretation Method on Patient Satisfaction in an Urban Walk-In Clinic," *Journal of General Internal Medicine* 17, no. 8 (2002): 641–645 and David and Rhee, "The Impact of Language" via Ku, 2005.

18 Betancourt, et al. "Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches." Field Report, October 2002.

19 Fortier JP and Bishop D. *Setting the Agenda for Research on Cultural Competence in Health Care.* Brach, C., editor. August 2004. Office of Minority Health and Agency for Healthcare Research and Quality. http://www.ahrq.gov/research/cultural.htm

20 Karliner LS, Jacobs EA, Chen AH, Mutha S. "Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency?" A systematic review of the literature. *Health Serv Res.* 2007 Apr; 42(2): 727–54.

21 Jacobs EA, et al. "The Impact of Interpreter Services on Delivery of Care to Limited-English-Proficient Patients," *Journal of General Internal Medicine* 16, no. 7 (2001): 468–474.

22 Jacobs EA, et al. "Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services," *American Journal of Public Health* 94, no. 5 (2004): 866–869.

23 Rivadeneyra R, et al. "Patient Centeredness in Medical Encounters Requiring an Interpreter," *American Journal of Medicine* 108, no. 6 (2000): 470–474.

24 Baker DW, Hayes R, and Fortier JP. "Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients," *Medical Care* 36, no. 10 (1998): 1461–1470.

25 Hampers LC, et al. "Language Barriers and Resource Utilization in a Pediatric Emergency Department." *Pediatrics* 103 (June 1999, Part 1): 1253.56.

26 Kaiser health care interpreter certification program. Kaiser Permanente: Health Care Interpreter Certificate Program [Internet]. Washington; c2008 [cited 2010 Mar 10]. Available from: http://www.rwjf.org/pr/product.jsp?id=34036

27 Certification Commission for Healthcare Interpreters Certification program (CCHIC.org). Certification Commission for Healthcare Interpreters (CCHI) [homepage on the Internet]. Washington; 2009. Available from: http://www.healthcareinterpretercertification.org/

28 National Board for Certification of Medical Interpreters convened by International Medical Interpreters Association and Language Line Services. National Board for Certification of Medical Interpreters. Washington; 2010. Available from: www.certifiedmedicalinterpreters.org

29 Ku L, Flores G. "Pay Now Or Pay Later: Providing Interpreter Services In Health Care." *Health Affairs*, 24, no. 2 (2005): 435–444.

30 National Committee for Quality Assurance. *Innovative Practices In Multicultural Health Care.* 2006. http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLASInnovativePrac_06.pdf

31 National Committee for Quality Assurance. *Innovative Practices In Multicultural Health Care.* 2008. http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLASInnovativePrac_08.pdf

32 American Medical Association. *Eliminating Health Disparities: Research Findings and Recommendations.* Available at: http://www.ama-assn.org/ama/pub/physician-resources/public-health/eliminating-health-disparities/research-findings-recommendations.shtml

33 Association of American Medical Colleges. Cultural Competence Education. May 2005. Available at: http://www.aamc.org/meded/tacct/culturalcomped.pdf

34 Street RL Jr, O'Malley KJ, Cooper LA, Haidet P. "Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity." *Annals of Family Medicine.* 2008 May-Jun; 6(3):198–205.

35 Evans RM. "Increasing Minority Representation in Health Care Management. *Health Forum Journal* 1999; 42:22.

36 Reports from the National Hispanic/Latino Health Initiative (NHLHI). *Public Health Rep* 1993; 108:534–58.

37 Nickens HW. The rationale for minority-targeted programs in medicine in the 1990s. *Journal of the American Medical Association* 1992:267:2390,2395.

38 Cohen JJ, Gabriel BA, Terrell C. "The case for diversity in the health care workforce." *Health Affairs.* 2002 Sep–Oct; 21(5): 90–102.

39 National Committee for Quality Assurance. *Innovative Practices in Multicultural Health Care.* 2009. http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_InnovPrac_09.pdf

40 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

41 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

42 Centers for Medicare and Medicaid Services. *Quality Improvement Organizations: Overview.* Updated January 2010. http://www.cms.hhs.gov/QualityImprovementOrgs/

43 Centers for Medicare and Medicaid Services. *Quality Improvement Organizations. 8th Scope of Work.* http://www.cms.hhs.gov/QualityImprovementOrgs/downloads/8thSOW.pdf

44 Centers for Medicare and Medicaid Services. Office of Public Affairs. "Fact Sheet: Medicare Releases Solicitations For Quality Improvement Organizations' 9th Statement Of Work;" "Goal Of Three-Year Contract Is to Promote Quality and Safety of Care for Medicare Beneficiaries and Improve Management of QIOs." Tuesday, February 05, 2008. Available at: http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2880&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=qio&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date