StratisHealth

CULTURE CARE CONNECTION

www.culturecareconnection.org

Increasing the cultural competence of health care providers serving culturally diverse populations

Spring 2013

Funded by UCare

CCC II Post-CLAS Assessment Clinic Results Are In

The Culture Care Connection II initiative is winding down, with the post-CLAS assessment results in for 21 clinics.

We are excited to report that four of the most important of the CLAS standards in the assessment (listed below) showed statistically significant improvement in the aggregate clinic results.

- Standard 1 – Improvement in overall cultural competence
- Standard 5 – Improvement in providing language access services to patients
- Standard 6 – Improvement in communicating to patients (verbally and in writing) their right to language assistance services
- Standard 10 – Improvement in data collection of race, ethnicity, and language

Statistically significant improvement in these four standards is especially important because they address critical issues that show clinics are dedicated to improving the cultural competence of their staff and health equity for their patients.

Results show clinics are now making a regular practice of providing language access services and communicating the availability of those services to their patients, and a significant change in clinic practice shows clinics are now more than ever implementing data collection on race, ethnicity, and language.

Research shows that the first step to addressing disparities in health and health care is to truly understand where those disparities exist — and you can't improve what you can't measure.

Stratis Health's CLAS assessment is based on the national Culturally and Linguistically Appropriate Services (CLAS) Standards. On April 24, 2013, the Office of Minority Health released the Enhanced CLAS Standards (see article on page 2). Stratis Health will be updating our CLAS assessment tools to reflect the changes. We also are exploring ways to bring stakeholders together to discuss creation of a statewide collaborative around culture.

This Issue

For more information on how your organization can get involved in future activities related to cultural competence and the Enhanced CLAS Standards, contact Program Manager Mary Beth Dahl, 952-853-8546, mdahl@stratishealth.org.

Enhanced CLAS Standards Just Released

A Blueprint for Advancing and Sustaining CLAS Policy and Practice

An important step for health care organizations to eliminate health and health care disparities is to implement the enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards, just launched on April 24, 2013.

Created in 2000, the original 14 CLAS standards were developed to improve the health of racial and ethnic minority populations through the development of health policies and programs. The enhanced standards provide a framework for health organizations to use to ensure all their underserved patients receive equitable and effective treatment. Embedding a structure for fostering cultural and linguistic competence throughout an organization plays a critical role in helping providers personalize care and tailor improvement strategies to their patient populations.

What's New?

- The goal of the enhanced standards has been expanded to eliminating disparities in health, as well as health care.
- All CLAS Standards are now considered of equal importance; in the original 14 standards, each standard was designated as a recommendation, mandate, or guideline.
- The enhanced standards have been reorganized from the original three categories: Culturally Competent Care, Language Access Services, and Organizational Supports to the following categories:
  - Principal Standard: a statement of intent
  - Governance, Leadership, Workforce
  - Communication and Language Assistance
  - Engagement, Continuous Improvement, Accountability
- The explicit definition of health now addresses physical, mental, social, and spiritual well-being.
- The definition of culture has been expanded from racial, ethnic, and linguistic groups to include geographical, religious and spiritual, biological and sociological characteristics.
- A new standard has been added to the original 14: Standard 2, *Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.*

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice (The Blueprint), offers a user-friendly format with comprehensive information on each standard. The Blueprint is an implementation guide for advancing and sustaining culturally and linguistically appropriate services within health and health care organizations, with one chapter dedicated to each of the 15 Standards. The chapters review the standard's purpose, components, and strategies for implementation, and include guidelines and additional resources.

The Enhanced CLAS Standards were developed by the Office of Minority Health through partnerships, networks, research, demonstrations, and evaluation, and have been coordinated with the Affordable Care Act and other cultural and linguistic competency standards (e.g., Joint Commission, National Committee for Quality Assurance). https://www.thinkculturalhealth.hhs.gov/

Enhanced CLAS Standards, April 24, 2013

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. *NEW!*
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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NEWS

Many Faces of Minnesota

According to the U.S. Census, Minnesota's foreign-born population has grown dramatically since the 2000 census — outpacing the national growth rate. However, with only 6.9 percent foreign-born residents, Minnesota is still less diverse than many other states. In 1900, 28.9 percent of the population were foreign born.

More than 80 percent of Minnesota's foreign-born residents live in the Twin Cities seven-county region. Ramsey and Hennepin counties have the largest foreign-born populations, at approximately 13 percent each. The largest groups of foreign-born residents in Minnesota according to the *Minnesota Compass* are from: Mexico, Laos, India, Somalia, Vietnam, Canada, Ethiopia, Korea, Liberia, China, Thailand, Germany, Kenya, the Philippines, and Cambodia.

With the retirement of the baby boomers over the next decade, immigrants and their children, who are generally younger than the native-born population, will help make up Minnesota's declining workforce. Educating immigrant children has become a state and national priority for preparing them to fully participate in the workforce and broader community.

Wilder Foundation Studies Minnesota's Foreign-Born Populations: "Speaking for Ourselves"

The Wilder Foundation in St. Paul is conducting a second community assessment of Minnesota's refugee and immigrant populations, focusing on their needs and challenges to accessing services.

Researchers considered the Cambodian, Hmong, Karen, Latino, Oromo, Somali, and Vietnamese populations as subjects for the second study, "Speaking for Ourselves." Results are expected in fall 2013.

Wilder's original study, "Speaking for Themselves," conducted in 2000 focused on Hispanic, Hmong, Russian, and Somali populations.

Mental Health Screening for Refugees

In late 2012, Minnesota's Refugee Health Program convened a group of refugee health screening providers, mental health practitioners, local public health, and health plans to review recommended mental health screening guidelines for the initial domestic refugee health assessment.

The initial assessment is an ideal opportunity to integrate mental health screening into the screening protocol; however, there are significant time constraints and barriers that can prevent meaningful access to care. Barriers include lack of transportation, culturally competent clinicians and staff, timely mental health appointments, and problems navigating the health care system. These barriers are compounded by refugees and their families having to deal with the stigma associated with mental health issues.

The group addressed the following questions:

> *What can be done during the initial refugee health screening, within the first 90 days of arrival, to improve the identification and referral of those who have mental health needs (e.g., any mental health issue that could interfere with necessary adjustment and resettlement)?*
>
> *Is there a validated and appropriate screening tool for various refugee populations that could be included in the state's screening recommendations?*

Final recommendations to be released in late 2013 are expected to provide practical guidance for providers to address mental health concerns.

Minnesota Community Health Worker Alliance Creates Standardized Competency Training

Community health workers (CHW) usually share ethnicity, language, socioeconomic status, and life experiences with the people they serve. They assist underserved residents of all ages in gaining access to coverage, screenings, care, and social services; in navigating a complicated health system; and in expanding their health knowledge and self-care skills through health education and coaching. From 2004 to 2009, Minnesota State Colleges and Universities worked with educational institutions, health systems, government agencies, businesses, and nonprofits to promote the role of CHWs in Minnesota. The partnership created a statewide standardized training to support CHW services, developing a standardized credit-based curriculum of 14 credits and seven courses of classroom and field-based training. More than 300 students have completed the curriculum and obtained certification. In 2012, the Agency for Healthcare Research and Quality recognized the Alliance as an evidence-based innovation in its Innovations Exchange program.

MORE NEWS

Meeting the Demand for Trained Medical Interpreters

Being unable to communicate symptoms and medical history to a health care professional is an ongoing health risk and patient safety issue for patients who cannot speak English or have limited English proficiency. Trained medical *interpreters* are required to convert the spoken words of patients and health care providers from one language to another (*translators* convert written documents).

Although medical providers are required to provide interpreters, there is a shortage of trained, skilled medical interpreters. The National Board of Certification for Medical Interpreters lists only 500 certified interpreters to meet this growing need.

In the past, untrained bilingual employees and patient families have been used as interpreters, but the practice is now deemed unsatisfactory and dangerous. The Director of the national Office for Civil Rights of the Department of Health and Human Services Leon Rodriguez cited a study that showed rates of negative medical outcomes according to interpreter assistance: 2 percent negative outcomes with a **trained** interpreter; 20 percent with **no** interpreter; and 22 percent with a **family** member as interpreter

Many health care organizations now use phone or video technology to meet the demand, or contract with organizations that train and certify interpreters in medical terminology, ethics, and cultural differences, including Minnesota's CentraCare Health System. In a USA Today article, CentraCare staff described the system's practice of contracting with interpreter organizations, citing the top languages in demand in central Minnesota as Spanish and Somali.

Roadmap to Reduce Disparities

Get the latest information on what works in reducing health disparities in this guide from the Robert Wood Johnson-funded research project, Finding Answers: Disparities Research for Change.

The Roadmap's six-step framework helps integrate disparities reduction into health care quality improvement efforts; is designed to be flexible, allowing organizations to get on the road where they need to; and supports a comprehensive approach to achieving equity, even though the causes of disparities may vary across regions or patient populations.

The project evaluates a variety of intervention strategies in different health care settings to find out what works and what does not work in improving care. The Roadmap is based on lessons learned from funded projects, and reviews of disparities-reduction literature. The intent is to spread information to health care systems so they can incorporate successful strategies into their quality improvement efforts. Its programs target diabetes, cardiovascular disease, and depression — all conditions where the evidence of racial and ethnic disparities is strong and recommended standards of care are clear.

Culturally Competent Somali Childbirth

The University of Minnesota School of Public Health, Medica, and the law firm of Nilan Johnson Lewis sponsored a recent event highlighting the health concerns of Somali

women in the U.S., specifically conflicting models of care, infertility, and genital cutting.

Nancy Deyo of the Women's Refugee Commission presented a study comparing childbirth in Somalia, refugee camps, and the U.S. Mary Malotky, a midwife at Hennepin County Medical Center described her experiences with Somali women and the need for providers to recognize the fears associated with childbirth and infertility, a source of great anxiety for Somali women. The more children a woman has, the more she is valued. Infertility can result in depression, poor self-esteem and isolation for Somali women, as well as lack of community support.

Because 98 percent of Somali women have genital cutting, it is critical for providers to raise this very sensitive issue with Somali women during prenatal care — by at least the third trimester. Most Somali women will not bring up the subject.

Other speakers included Fartun Weli, founder and director of Isuroon, a Somali non-profit seeking health and empowerment for Somali women;

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MORE NEWS

Daniel Wordsworth president of the American Refugee Committee, and Stephanie Walters, medical director, Macalester University. More >>

Dementia Capable Communities Toolkit Available from ACT on Alzheimer's

A new community toolkit is available from ACT on Alzheimer's to help prepare Minnesota for the personal, social, and budgetary impacts of Alzheimer's disease and related dementias. Currently, 100,000 Minnesotans live with Alzheimer's disease, and the number is growing. The rise in the number of Minnesotans with Alzheimer's disease and other dementias will bring enormous cost and burden to those with the disease, their families, our communities, and the state.

Working in conjunction with ACT on Alzheimer's, Stratis Health led development of the Dementia Capable Communities Toolkit, which gives communities a process for coming together and planning how to become dementia capable. This process will strengthen communities, improve overall services, support caregivers, and prepare health care professionals, clergy, service staff, and others who want to know how to best support individuals touched by Alzheimer's. Five action communities are piloting the toolkit — St. Paul Neighborhood, St. Louis Park, Twin Cities Jewish Community, Walker, and Willmar.

The toolkit's Dementia Capable Community Assessment addresses language and cultural issues for diverse and underserved populations. Your community can determine if a particular population has a need for resources tailored for people with dementia and their families, such as signage and images depicting them or materials in a particular language, or messages that address cultural beliefs and values.

Health care professionals play a critical role in a dementia capable community, from early identification and diagnosis to medical management and patient and family/caregiver education. Trained, dementia competent medical professionals can provide a definitive diagnosis of Alzheimer's disease, which includes a medical and psychiatric history, a physical and neurological exam, an evaluation of the person's functional ability and mental status, and a family or caregiver interview.

To learn the ways you can act, visit ACT on Alzheimer's.

JAMA Reports Reduced Hospital Readmissions in Medicare QIO Study

The January 23/30 issue of the Journal of the American Medical Association (JAMA) highlighted a recent community-based pilot study that showed 30-day hospital readmissions reduced by nearly 6 percent. The study was conducted by Medicare Quality Improvement Organizations (QIOs) across the nation. With one in five Medicare patients returning to the hospital within 30 days of discharge and Medicare payments making up more than half of hospital revenue, the 14 communities participating in the study saved millions of dollars in hospital bills and kept thousands of Medicare beneficiaries with complex follow-up care out of the hospital (in poor and affluent communities). A 2010 health reform law now penalizes hospitals with high rates readmisssions for Medicare patients with acute myocardial infarction, heart failure, or pneumonia. The law also created incentives for hospitals to prevent readmissions by improving discharge processes and transitions from the hospital to the community. All 14 communities involved in the study documented significant reductions in readmissions. In Minnesota, similar work is being conducted through the RARE Campaign, led by Stratis Health and partners, http://www.rarereadmissions.org.

RESOURCES

Refugee Health Quarterly

Get regular updates on new developments in state refugee health by subscribing to the Minnesota Department of Health Refugee Health Quarterly. Find data on countries of origin for new refugee arrivals, news on a recent Public Health/Volunteer Agency forum, a report on efforts to manage complex medical and mental health cases among new refugees, and more.

"Disparities in Health and Health Care: Five Key Questions and Answers"

Read this recently published report from the Kaiser Family Foundation on what health care disparities are—not only for racial and ethnic groups—but also for groups identified by socioeconomic status, geographic location, age, and language. The report also describes the status of health disparities today and current national efforts to reduce disparities, including terms outlined in the Affordable Care Act.

Clarify Your Translation Process

Improve the quality of your in-house and vendor-prepared translations with the More Than Words Toolkit from Hablamos Juntos and the Robert Wood Johnson Foundation. It clarifies the translation process and provides a roadmap to help health care organizations get better results. The toolkit draws on scientific literature and research on translation quality, with the following hands-on tools:

- Getting Started with Translations in Health Care
- Five Steps to Improve Health Care Communication with Limited English Proficiency Populations
- Developing the Translation Brief: Why & How
- Creating a Translation Brief for: Informed Consent Forms
- Guide to Informed Consent, With Tools For Providing Simple And Effective Informed Consent In Everyday Clinical Practice
- Assessing Translation Quality – A Manual for Requesters
- The Translation Quality Assessment Tool

EVENTS

Minnesota Healthcare Quality Professionals (MHQP) 2013 Educational Webinars

The following MHQP webinars are held the third Thursday of the month, noon – 1 p.m. For more information contact Mary Larweck.

- June 20: Interpreting data
- September 19: Lean quality tools
- October 17: Quality tools – force field analysis
- November 21: Benchmarking (and MHQP annual meeting)

9th Annual Minnesota e-Health Summit Minnesota e-Health: Optimizing, Connecting, Transforming June 12-13, 2013, Bloomington

This year's educational Summit explores how optimizing the use of electronic health record systems (EHRs) and other health IT to connect health information is transforming health care and public health. New location this year: The DoubleTree hotel in Bloomington.
Brochure Register

Twin Cities World Refugee Day June 15, Wellstone Center, St. Paul, MN

Plan to attend this annual festival, which celebrates the more than 95,000 refugees living in Minnesota and the diversity of cultures, experiences, and assets they bring to our community. Since 2001, people all over the world have celebrated World Refugee Day, honoring the world's 11 million refugees. See performances, resources, and vendors from around the world. Noon to 5:00 p.m.

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EVENTS

Rural Health Conference June 24-25, Duluth

The Minnesota Rural Health Conference showcases creative solutions to challenges in rural health care and encourages leadership for the future. More >>

National Healthcare Quality Week, October 20-26

The week aims to highlight the work of health care quality and patient safety professionals and their influence on improved patient care outcomes and health care delivery systems.

Antimicrobial Stewardship: Chapter 2, October 24

Antimicrobial resistance is a significant health care quality and patient safety issue. We now have infections that are virtually untreatable with currently available therapies. Mark your calendars for the Antimicrobial Stewardship Chapter 2, a CHAIN-sponsored follow-up to last year's successful kickoff conference which presented a variety of effective strategies for antimicrobial stewardship programs throughout Minnesota. Intended audience: hospital staff and clinicians, including medical directors, ED physicians, infectious disease physicians, infection preventionists, clinical pharmacists, quality directors, and administrators. More information to follow.

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works toward its mission through initiatives funded by federal and state government contracts, and community and foundation grants, including serving as Minnesota's Medicare Quality Improvement Organization.

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