GUIDELINES FOR CULTURAL AND LINGUISTIC COMPETENCE

The purpose of providing Cultural and Linguistic Competence guidelines is to promote standards that will effectively address health inequalities traditionally experienced by people and families in the OPWDD system of care due to race, ethnicity, gender, sexual orientation, national origin, disability, limited English proficiency, and/or hearing impairment.

Developing a Strategic Plan

The best for way for providers to become truly culturally competent is to create a strategic plan. To assist with that process, these suggested questions outline an organizational assessment that providers should undertake to assess if they meet the goals of a Cultural and Linguistic Competence. The goals are to:

- Ensure that no program denies care and treatment to, or otherwise discriminates against, any individual based on race, ethnicity, gender, sexual orientation, national origin, disability, limited-English proficiency, and/or hearing impairment.
- Assist in evaluating the cultural and linguistic competence of individual and organizational practices, while implementing practices that address the histories, traditions, beliefs, languages, and value systems of culturally diverse groups.
- Provide a tool whereby each program/agency can ensure that the care it provides is culturally and linguistically competent.

Organizational Checklist

When assessing cultural and linguistic competence ("readiness") the following checklist identifies areas that should be reviewed:

Language Provision

- What internal policies/procedures need to be developed for serving people who have a communication barrier?
- Has an assessment of communication barriers for individuals and families seeking services been conducted? Take into consideration translating the following documents:

  - Any written instrument intended to provide information or education to the individual
  - Medical record forms
  - Department signage
- Is the preferred language (including American Sign Language) for receipt of information recorded in a person's clinical record?
- Are individuals informed of their right to a qualified interpreter/translation service at no charge?
- Does the organization/agency have the appropriate equipment to use telephonic interpreting services?
- Has bilingual staff at the facility been identified?
- Does the organization/agency have TTY and assistive-listening devices available?
- Have key documents/policies been translated into the languages most common to the populations served in a region?

Integration of Culturally Competent Services

- Have policies and procedures been developed to address the needs of traditionally underserved populations that include, but are not limited to, race, ethnicity, gender, sexual orientation, national origin, people with disabilities, persons who are limited-English proficient and individuals who are deaf and/or hard-of-hearing?
- Do these policies and procedures identify the data and information to be gathered during psychosocial, emotional, health and behavioral assessments? Such screening should include:
  - Religion, spiritual beliefs, values and preferences
  - Ethnic and cultural factors
  - Social factors
  - Communication skills
  - Family circumstances
- Is the assessment information reflected in the clinical record and used to determine available treatment and services?
- Has a process been developed by which the person and/or family members are informed of their rights while receiving care, including:
  - The right to have a language interpreter

  - The right to receive an accommodation for a disability
  - The right to be free from discrimination when receiving care
  - The right to designate a surrogate decision-maker
- Has signage of relevant policies and persons' rights been posted in public places, in plain language, and in the most common languages spoken by the individuals and families served?
- Have collateral supports been developed with providers, community leaders, and family members to benefit and integrate the cultural, ethnic and social factors that will improve treatment services for the person in care?
- Is the physical environment welcoming to a diverse population?
- Have appropriate steps been taken to ensure each individual's dignity, autonomy, positive self-regard, civil rights, and right to the involvement in his or her care throughout the course of assessment and service provision? This includes:
  - Carefully planning and providing care, treatment, and services with regard to the person's personal values, beliefs, and preferences, which reflect the person's cultural, ethnic and religious heritage;
  - Supporting rights through quality interactions with individuals by involving them in decisions about their care, treatment, and services;
  - Ensuring that health information is understood by infusing health literacy strategies into discussions and materials;
  - Basing education and training for staff on each person's need and abilities;
  - Accommodating a person's cultural, religious, or ethnic food and nutritional preferences, unless contraindicated;
  - To the extent possible, providing care and services that accommodate the person and their family's comfort, dignity, psychosocial, emotional, and spiritual end -of-life needs; and ,
  - Accommodating the person's right to religious and other spiritual services.
- Do plans for services reflect the roles and participation of the person's designated family members who may be providing supports?

Workforce Development

- Are in-service and other education and training opportunities provided to staff to instruct them on how to provide culturally and linguistically competent services?

- Is this training provided regularly? It is recommended that it be provided at the time of staff orientation and on an annual basis, and does it include effective communication, cultural competence, and person and family-centered care information?
- Have efforts been made to recruit staff to create a diverse workforce and increase the ethnic and language concordance between staff and persons served?
- Is staff provided with opportunities to voice concerns and make suggestions regarding how to meet unique individual and family needs, including cultural, religious, spiritual, and mobility requests?

Data Collection and Outcomes

- Is data collected on race, ethnicity, language, religion, spirituality, sexual orientation, age, gender, and other specific information for the purposes of quality improvement?
- For planning purposes, and to allow for assessment of success in providing culturally and linguistically competent care, is data obtained on the demographic composition of the community served, and has a cultural profile of the population served been developed?
- Is there a process for gathering feedback from persons, families and representatives of the community served, using existing vehicles such as satisfaction surveys, complaint resolution structures, the Board of Visitors, and any new methods that arise out of an agency or community database?

Outreach and Engagement

- Is information about agency services, programs, and initiatives responsive to cultural and linguistic needs, including availability to the family?
- Does the agency/organization attempt to establish relationships with religious leaders for facilitating the process of an individual's right to practice his or her faith?
- Does the agency/organization collaborate with community organizations, peer groups, and other vested stakeholders in the creation of services and programs available to the community?
- Is there a deliberate process to engage various stakeholders across the organization/agency to collaborate on cultural and linguistic initiatives?
    - Committees may consist of:

- Staff (at all levels of the organization)
- Individuals and families served
- Community leaders
- Religious leaders

Training

Agency/organization training directors should consider the following strategies when planning cultural and linguistic competence training:

- Provide all new staff with a course on cultural and linguistic competence training. Provide on-going opportunities for staff to learn about culturally competent care, cultural awareness, and issues with specific limited-English proficient communities in their catchment area.

Helpful Definitions

The following glossary of terms is to be used in the context of cultural and linguistic competence:

- **Bilingual employee**: an employee or volunteer who self-identifies as having the ability to speak, read, and write English, as well as another language, which could include American Sign Language.

- **Cultural Competence**: the ability of providers and organizations to understand and respond effectively to the cultural and language needs brought by the individual and family member to an encounter. Cultural competence can be demonstrated on both an organizational and individual service level, as described below:

- ***Organizational Cultural Competence*** – A set of congruent behaviors, attitudes, skills, policies, and procedures that are promoted and endorsed to enable caregivers at all levels of the organization to work effectively with persons and communities of all cultural backgrounds. An important element of cultural competence is the capacity to overcome structural barriers in healthcare delivery that sustain health and healthcare disparities across cultural groups.

- ***Individualized Service Delivery*** - means that providers will consider culture-specific elements of a person's lifestyle such as emotional expression, familial living arrangements, or recreational activities. Considering these elements facilitates accurate diagnosis and treatment planning that reaches across cultural boundaries, and is acceptable to persons and their families.

- ***Cultural Group*** – a group identified as requiring special attention, since features of its "culture" may affect the way its members perceive, access, or participate in, mainstream service-delivery systems.

- ***Culture*** – the shared values, traditions, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, nationality, language, religious beliefs, spirituality, socioeconomic status, social class, sexual orientation, politics, gender, age, disability, or any other cohesive group variable.

- ***Dea***f – an individual whose hearing is totally impaired or whose hearing, with or without amplification, is so seriously impaired that the primary means of receiving spoken communication is through visual input such a lip-reading, sign language, finger spelling, reading or writing, or a combination of modes. An individual may be identified as being "deaf" based on language use, cultural affiliation, social preferences, and/or self-determination.

- ***Disparity*** – When used in the context of health and behavioral healthcare, this term generally means a difference in health and behavioral healthcare provided to persons of a particular racial and/or ethnic group that are not attributable to other known factors. These factors include gender, race, ethnicity, education, income, disability, geographic location, and/or sexual orientation. Compelling evidence indicates that race and ethnicity correlate with persistent and increasing heath disparities among the U.S. population *(Office of Minority Health and Health Disparities, 2009)*. Disparities need to be monitored and addressed.

- ***Effective Communication*** – The successful joint exchange of information that enables individuals to participate actively in their own care from admission through discharge. Effective communication is a two-way process in which information is exchanged until both parties achieve an accurate, common understanding. Effective communication takes place only when providers understand and integrate the information gleaned from individuals, and when individuals receiving services comprehend accurate, timely, complete, and

unambiguous messages from providers in a way that enables them to participate responsibly in their care.

- ***Family*** – The term "family" should be interpreted broadly to mean two or more persons who are related in any way- biologically, legally, or emotionally.

- ***Gender Expression*** – The external characteristics and behaviors of individuals that are socially defined as either masculine or feminine, such as dress, grooming, mannerisms, speech patterns, and social interactions. Social or cultural norms can vary widely, and some characteristics that may be accepted as masculine, feminine, or neutral in one culture may not be assessed similarly in another. (See also *Gender Identity* and *Sexual Orientation*)

- ***Gender Identity*** – *A* person's innate, deeply felt psychological identification as a male or female, which may or may not correspond to the person's body or the gender originally listed on a person's birth certificate. A person's gender identity is distinct from his or her sexual orientation.

- ***Hard-of-hearing*** – An individual whose hearing is impaired to such an extent that hearing is difficult, but that such impairment does not preclude the understanding of spoken communication through the ear alone, with or without a hearing aid or other prosthetic device (e.g., cochlear implant).

- ***Health literacy*** – The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

- ***Interpreter*** A person who renders a message spoken/signed in one language into one or more additional languages. (See also *Qualified Interpreter*).

- ***Language Service***s – Mechanisms used to facilitate communication with individuals who do not speak English, those who have limited-English proficiency, and those who are deaf or hard-of-hearing. These services can include in-person interpreters, bilingual staff, or remote interpreting systems such as telephone or video services. It is also the process in place to provide translation of written materials or signage.

- ***Limited English Proficiency (LEP)*** –The inability to speak, read, write or understand English at a level that permits an individual to interact effectively with healthcare providers or social service agencies without the assistance of an interpreter.

- ***Natural/Community Supports*** – Natural supports are friends, family members, coworkers, community members, other non-paid, and naturally occurring relationships that support and assist an individual in an integrated and community-based setting.

- ***Person-Centered Planning (PCP)*** – A process that focuses on the capabilities and strengths of an individual to create a vision of a desirable future. It focuses on each person's gifts, talents, and skills, not on deficits and deficiencies. It is an ongoing process of social change wherein the service coordinator works with the person with disabilities and people who pledge their support to that person to identify the individual's vision of their best life, and to pursue that vision within their community.

- ***Plain language*** – This is a strategy for making written and oral information easy enough to understand the first time an individual reads or hears it. A plain language document is one in which people can find what they need, understand what they find, and act on that understanding.

- ***Qualified Interpreter*** – A trained professional who has been assessed for professional skills and who demonstrates a high-level of proficiency in at least two languages.

- ***Self-Determination (SD)****:* promotes the concept that people served have a free choice of services, supports, and methods of service delivery; that they may design their own service plan and manage their own Consolidated Supports and Services (CSS) budget. Choice is enhanced because in many cases service is no longer restricted to only Medicaid providers. There are five primary principles of the Self-Determination philosophy, which are: freedom, authority or control, support, responsibility, and self-advocacy.

- ***Self-Direction*** – Gives individuals and families greater control over the services they receive, how they receive them, and who provides them. At the same time, people who self-direct must be willing to take on the responsibility of co-managing their services.

- ***Sexual orientation*** – An individual's physical and/or emotional attraction to the same and/or opposite gender. Heterosexual, bisexual, and homosexual are all sexual orientations. A person's sexual orientation is distinct from a person's gender identity.

- ***Surrogate Decision-Maker*** – Someone appointed to make decisions on behalf of another. A surrogate decision-maker makes decisions when an individual is without decision-making capacity, or when an individual has given written permission to the surrogate to make

decisions. Such an individual is sometimes referred to as a "legally responsible representative."

- ***Translatio***n – A process through which written communication is converted to another language that has a meaning equivalent to that of the original.

- ***TTY*** – A keyboard-style electronic device. Also known as TDD or TT, the device is capable of transmitting and receiving messages from another such device over the telephone or computer.