

Caring for Diverse Populations: Do Academic Family Medicine Practices Have CLAS?

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Background and Objectives: *The Future of Family Medicine Final Report calls for greater emphasis on training physicians to provide culturally proficient and effective quality care to an increasingly diverse population. It remains unclear, however, how prepared academic family medicine practices are to address this need. Methods:* We carried out a qualitative sub-study (as part of a larger research study) using depth and focus group interviews at two urban family medicine centers to understand the challenges and opportunities involved in meeting the Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. The Lewin Group's Organizational Cultural Competence Assessment Profile was used to analyze the qualitative interview data. **Results:** The main themes that emerged from interviews with faculty physicians, administrators, staff, and patients were: (1) the need for more linguistically appropriate services, (2) lack of communication among those involved in care delivery, and (3) interest in education about cultural and linguistic competence. **Conclusions:** The academic family medicine practices studied are frustrated and challenged to integrate cultural and linguistic competence into patient care. Organizational pressures, multiple competing demands, and resource constraints inhibit preparedness to address the CLAS standards and important new national requirements and guidelines.

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The recently published *Future of Family Medicine Final Report*¹ calls for a new practice model that stresses cultural proficiency and effectiveness in delivering equitable services to diverse populations. This is consonant with emerging accreditation, contractual, and regulatory requirements; liability and malpractice concerns; and an increasingly competitive health care marketplace that demands improved quality of care, greater patient safety, and the elimination of health disparities.²⁻⁹

Three recent Institute of Medicine reports focus on these issues, emphasizing the need for (1) reform in providing patient-centered, effective, efficient, safe, timely, and equitable care,¹⁰ (2) preparation of health professionals to address the nation's increasingly diverse population,¹¹ and (3) integration of cross-cultural education into health professions education to improve quality of care and reduce health care disparities.¹²

Cultural competence has been promoted as an important strategy for addressing these needs.¹³⁻¹⁹

A widely accepted definition of cultural competence is "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system that offers the highest quality care to every patient, regardless of race, ethnicity, cultural background, or English proficiency."²⁰

To guide the development of cultural competence, the Office of Minority Health published 14 National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care²¹ (Table 1). Our study examined the perceptions of faculty physicians, administrators, staff, and patients about the CLAS standards and the preparedness of two academic family medicine practices to provide culturally and linguistically competent care.

Methods

Study Design

This was a qualitative research study, within our larger Aetna Foundation-funded, multi-method, 2-year project, implemented at two large urban family

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Table 1

The US Department of Health and Human Services Office of Minority Health National Standards
for Culturally and Linguistically Appropriate Services (CLAS) in Health Care*

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should 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.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited-English-proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. 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 culturally and linguistically appropriate services.
9. 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.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

* The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served. The 14 standards are organized by themes: Culturally Competent Care (Standards 1–3), Language Access Services (Standards 4–7), and Organizational Supports for Cultural Competence (Standards 8–14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows: CLAS mandates are current federal requirements for all recipients of federal funds (Standards 4, 5, 6, and 7). CLAS guidelines are activities recommended by the Office of Minority Health (OMH) for adoption as mandates by federal, state, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13). CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

medicine centers affiliated with a medical school in the Northeast.²² We obtained feedback about the CLAS standards from physicians, staff, and patients during four individual semi-structured depth interviews and six focus group interview sessions.

Study Practices

The two family medicine centers were located in Central New Jersey. Each saw approximately 1,500–1,600 patient visits per month, with an insurance mix of 80% managed care, 10% indemnity insurance, and 10% Medicare. Faculty family physicians and other health care providers from the medical school worked out of each office, and a family medicine residency program was based at Practice A. The patients represented diverse racial, ethnic, and socioeconomic backgrounds, including African Americans (20%), Hispanic/Latino Americans (10%), Chinese (10%), and immigrants

from Central and South America, Southeast Asia, and the former Soviet Union.

Participating Physicians and Staff

Practice A physicians and staff were a diverse group that included individuals who self-identified as European American, African American, Asian American, and Hispanic/Latino. The clinical staff at practice A consisted of eight to ten part-time faculty family physicians, 28 family medicine residents, eight nurses (RNs and LPNs), three medical assistants, two managed care referral personnel, and three resource unit personnel. A practice manager and eight clerical staff worked in the front office and/or reception area. A number of physicians, medical assistants, and clerical staff were bilingual and spoke languages including Spanish, Chinese, Portuguese, French, and German.

Practice B physicians and staff were also a diverse group that included individuals who self-identified as European American, African American, Hispanic/Latino American, and Asian American. The clinical staff consisted of eight to ten part-time faculty physicians, a health policy fellow, six nurses (RNs and LPNs), and an acupuncturist. Six clerical workers, a front office supervisor, a triage nurse, and a practice manager worked in the front office and/or reception area. Languages spoken by the physicians, acupuncturist, and clerical staff included Spanish, Chinese, and German.

Data Collection/Study Instruments: Depth and Focus Group Interviews

After obtaining institutional review board approval for all depth and focus group interviews, we recruited participants from faculty, staff, and patients at each practice. The project was introduced to physicians at a Department of Family Medicine monthly faculty meeting and at practice staff meetings. Written memos and electronic messages were subsequently sent inviting study participation.

Patients were selected on the basis of either participation in prior quality improvement teams at the practices and/or by recommendation of the medical staff. Patients received written letters of invitation and were paid a \$50 gift certificate at the conclusion of the focus group. Recruitment by recommendation and payment for attendance are well-established focus group practices.²⁷

The first author (JAK) conducted depth interviews (Appendix 1) with Practice A's medical director and both practices' managers. JAK worked in the same family medicine department but was not employed by the practices and was not a clinical care provider. The co-investigator who interviewed Practice B's medical director also worked in the department but was not employed by the practices and was not a clinical care provider. Interviews lasted approximately 1 hour and were audiotaped. No problems in the interviewing process were reported.

Six focus groups were conducted by a trained group moderator (not employed by the practices) to explore perceptions about diversity-related issues in primary care and challenges in meeting the CLAS standards (Appendix 2). Two sessions were held for physicians, staff, and patients, respectively. Five to seven physicians from each practice participated. The two physician focus groups occurred the same day at the medical school after a monthly departmental meeting. The staff focus groups consisted of six to seven participants and were conducted at the respective practice sites in the morning before the office opened or during lunch hour. Each of two non-homogeneous ethnic patient focus groups was held at the two practices in the evening and consisted of five to six participants representing the dominant cultures seen at the practices. The moderator distributed consent forms for participants to read and sign.

All participants were asked to respond to the same six questions relating to the CLAS standards, including "How can physicians and other health care providers at your practice ensure that patients receive effective, understandable, and respectful care that is compatible with their health beliefs, practices, and preferred language?" and "How should your practice self-assess its current and ongoing organizational efforts to address the 14 CLAS Standards?"

Enlarged copies of the CLAS standards were placed on easels; individual copies were distributed along with consent forms for subject participation and audiotape recording. Each session was transcribed for follow-up analysis. Due to technical difficulties with recording of one practice's support staff focus group, the moderator used personal notes.

Conceptual Framework and Data Analysis

We used the Lewin Group's "Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile"²³ as the conceptual framework for understanding perceptions of faculty physicians, administrators, staff, and patients about the CLAS standards and the preparedness of the two practices to provide culturally competent care (Table 2). The Profile's development resulted from growing concern about the importance of cultural competence as a critical component of "accessible, responsive, and high-quality care." More than 120 literature sources were reviewed and synthesized, and input from service providers, managers, researchers, analysts, and policy makers informed the question, "How do we know cultural competence when we see it?" The Profile identifies seven "domains" and related "focus areas" (the observable and measurable characteristics of an organization that signify cultural competence) in which cultural competence should be evident. Site visits to health care organizations known for their innovative cultural competence activities helped validate the domains as appropriate performance areas for assessing cultural competence, informing quality improvement activities, addressing adherence with cultural competence standards, and conducting evaluative studies.

Data analysis followed an "immersion/crystallization" (I/C) approach, a well-developed qualitative study technique. I/C involved the analysts' immersion into, and reflection on, the transcribed text relating to both the Profile and the CLAS standards. The research team, JAK and RCL, read the original depth interview and focus group transcripts and reviewed the focus group summary prepared by the moderator, thus repeating the I/C cycle of insight and amalgamation until the reported interpretation was achieved.²⁴ This organizing framework enabled identification of dominant issues that emerged across participants. It also allowed us to test the utility of the domains and use it as a context for

Table 2

Indicators of Cultural Competence in Health Care Delivery Organizations:
an Organizational Cultural Competence Assessment Profile²³

<i>DOMAIN</i>	<i>FOCUS AREAS</i>
Organizational Values: An organization's perspective and attitudes regarding the worth and importance of cultural competence and its commitment to providing culturally competent care.	<ul style="list-style-type: none"> • Leadership, Investment, and Documentation • Information/Data Relevant to Cultural Competence • Organizational Flexibility
Governance: The goal setting, policy making, and other oversight vehicles an organization uses to help ensure the delivery of culturally competent care.	<ul style="list-style-type: none"> • Community Involvement and Accountability • Board Development and Policies
Planning and Monitoring/Evaluation: The mechanisms and processes used for: (a) long- and short-term policy, programmatic, and operational cultural competence planning that is informed by external and internal consumers and (b) the systems and activities needed to proactively track and assess an organization's level of cultural competence.	<ul style="list-style-type: none"> • Client, Community, and Staff Input • Plans and Implementation • Collection and Use of Cultural Competence-related Information/Data
Communication: The exchange of information between the organization/providers and the clients/population and internally among staff, in ways that promote cultural competence.	<ul style="list-style-type: none"> • Understanding of Different Communication Needs and Styles of Client Population • Culturally Competent Oral Communication • Culturally Competent Written/Other Communication • Communication With Community • Intra-organizational Communication
Staff Development: An organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge, and skills for delivering culturally competent services.	<ul style="list-style-type: none"> • Training Commitment and Training Content • Staff Performance
Organizational Infrastructure: The organizational resources required to deliver or facilitate delivery of culturally competent services.	<ul style="list-style-type: none"> • Financial/Budgetary • Staffing and Technology • Physical Facility/Environment
Services/Interventions: An organization's delivery or facilitation of clinical, public health, and health-related services in a culturally competent manner.	<ul style="list-style-type: none"> • Client/Family/Community Input • Screening/Assessment/Care Planning • Treatment/Follow-up

eliciting participants' major concerns and issues relating to delivery of culturally competent care.

The research team met weekly to review the preliminary categorization of themes; differences of opinion were discussed and resolved through further analysis. If consensus on the positioning of a key theme within a single domain could not be reached, a corresponding domain, considered equally applicable and/or relevant, was noted. Tables 3 and 4 integrate key themes relating to the seven domains with examples of participants' feedback about the CLAS standards.

Results

We found consistent high levels of frustrations, concerns, and challenges in both academic practices with respect to (1) the need for more linguistically appropriate services, (2) governance, (3) lack of communication among those involved in care delivery, and (4) interest in education about cultural and linguistic competence.

Linguistically Appropriate Services (CLAS Standards 1 and 8)

Particularly apparent were tensions regarding inadequate interpreter and language assistance services. Many issues appeared to stem from lack of control over organizational policies, as evidenced by use of untrained bilingual staff to interpret for patients during clinical encounters.

A majority of physicians expressed concerns about the practices being unprepared to respond effectively to patients' language needs, as typified by the comment, "We are talking about a practice that has a large diversity of patients that are non-English speaking, and we may not necessarily have somebody in the office at every moment who is able to speak those languages and could present a problem for a patient with an urgent need." They pointed out that "everyone works in a silo" and felt that lack of designated meetings to discuss issues contributed to inconsistent approaches. Support staff noted time pressures when serving non-English-speaking patients, commenting that the practice was responsible for increasing resources to improve interactions with diverse patient populations.

Table 3

Cultural Competence Domains—Feedback From Depth Interviews

<i>Cultural Competence Domains</i>	<i>Key Themes</i>	<i>Representative Examples of Responses to Interview Questions</i>
Organizational Values	<ul style="list-style-type: none"> • Not enough discussion about cultural competence at staff meetings 	<ul style="list-style-type: none"> • “Everyone works in a silo. Everyone has a different agenda. There is no day that the staff meet together to discuss issues.” (medical director) • “We have found that some of our providers tend not to integrate their practices into the group practice as readily as others. It gives the provider who cares for a specific cultural group more control over how this group is treated and also avoids problems that arise from staff not being culturally competent.” (medical director)
Governance	<ul style="list-style-type: none"> • No formal plan or guidance for interpreter services 	<ul style="list-style-type: none"> • “We are developing a new policy and procedure manual. I think it is just the whole mindset of the practice to provide for our patients as best we can.” (managers) • “We have no policy for training students and residents about cultural competence or ethnic diversity.” (medical director) • “No politics other than how to use the language line and access sign language interpreters. I am against using bilingual office staff in treatment rooms because it is risky and stressful. Recently the organization said that anyone not licensed or qualified to interpret can deny being that situation.” (office manager)
Planning and Monitoring/Evaluation	<ul style="list-style-type: none"> • No ongoing, formal process for tracking organizational cultural competence 	<ul style="list-style-type: none"> • “I would like to see feedback from our patients. Sometimes you are very surprised and you think things are going very nicely and smoothly and then you get feedback that the patient is uncomfortable. We certainly don’t want our patients feeling that way.” (managers) • “Language and understanding of how insurance works. What the patient related to the physician and the physician related to us. We were able to communicate with the insurance and got a no answer, and by the time we got back to the patient and explained it again, and they came back to us, and we went back to the insurance company, it was probably at least 7 days that the patient’s care was restricted because of communication between the office, the insurance company, and the physician.” (office manager)
Communication	<ul style="list-style-type: none"> • No standard, uniform approach to culture and language issues 	<ul style="list-style-type: none"> • “We are talking about a practice that has a large diversity of patients that are non-English speaking, and we may not necessarily have somebody in the office at every moment who is able to speak those languages and still could present a problem for a patient with an urgent need.” (office manager) • “Well, the Middle Eastern cultures—we have had a few residents we could see that there was a bit of a problem with the males treating the females.” (managers) • “I had colleagues who were African American, and they were trusted right away [by patients], and sometimes it worked out and sometimes it didn’t. I don’t think we have automatic authenticity or accountability with the patients.” (medical director) • “Maybe a patient survey from different cultures. Maybe putting it in their languages and having them tell us what they want from us and what they need and then taking that back to staff meetings once a month when we meet with the physicians.” (managers) • “I try to see if they [patients] have an interest in talking about alternative medicine. Or spirituality. But I don’t do a whole set of questions on that and probably should do more.” (medical director)
Staff Development	<ul style="list-style-type: none"> • Lack of training in cultural competence and patient-centered care for clinicians and staff 	<ul style="list-style-type: none"> • “Ongoing training activities that are continuous to improve our knowledge, skills, and attitudes.” (medical director) • “If you teach about cultures, you have to keep some general ideas, some general rule, or certain fundamental ideas about cultures. Where does the stereotyping begin, and where does cultural awareness begin?” (office manager) • “Dealing with the question of stereotype versus cultural awareness. Where on that continuum do you fall? And where is the truth in that?” (medical director) • “We don’t even know how to take a family history from different ethnic groups. We do it all the same way.” (medical director) • “I have seen e-mails going by from physicians and others in the office about where they can find information on cultural competence and how we can educate ourselves.” (office manager)
Services/Interventions	<ul style="list-style-type: none"> • Lack of culturally appropriate patient education resources 	<ul style="list-style-type: none"> • “Our biggest challenge is the language barrier. Who should be in the room with non-English-speaking patients, when, and under what circumstances? This comes up when children, family members, or even neighbors provide translation. This is also a huge problem with the telephone.” (medical director) • “We do need a lot more translation in terms of materials.” (medical director) • “Language problems. We try to give them appointments with Spanish-speaking doctors, and we have a few Spanish-speaking employees who help. A lot of times, they don’t have someone with them who speaks English, so it could be difficult.” (managers)

Table 4		
Cultural Competence Domains—Feedback From Focus Groups		
<i>Cultural Competence Domains</i>	<i>Key Themes</i>	<i>Representative Examples of Responses to Interview Questions</i>
Organizational Values	<ul style="list-style-type: none"> Numerous participants recognized that systematic analysis and improvement could help resolve problems encountered by patients 	<p><i>Question: “How can we ensure that patients receive effective, understandable, and respectful care that is compatible with their health beliefs, practices, and preferred language?”</i></p> <ul style="list-style-type: none"> “The office is staffed in a way that they really can’t sit and help even just a plain old non-reader fill out those forms. The office gets very backed up.” (support staff/reflects both practices) * Could also apply to Organizational Infrastructure domain.
Governance	<ul style="list-style-type: none"> Medical staff realizes it could benefit from additional resources in meeting the CLAS standards 	<p><i>Question: “What policies and/or procedures in line with the CLAS standards would help the practice become more culturally competent?”</i></p> <ul style="list-style-type: none"> Patients praise the open access initiative: “The best thing they ever did was add in the walk-in time in the morning. If you come in between 7:45 and 8:30 in the morning, they’ll see you without an appointment. If you say it’s an emergency, they will squeeze you in some time during the day. (patients/Practice B) * Could apply to Service/Interventions domain. “There should be wider recruitment of front desk staff among ethnic groups that could be more responsive to their needs.” (patients) “As a provider, I don’t know if the practice has done any assessment of CLAS. I don’t know if that’s been done, but I don’t think it should be by providers who don’t have any power to convert that information to practice.” (physician) * Could also apply to Service/Interventions domain.
Planning and Monitoring/Evaluation	<ul style="list-style-type: none"> No ongoing, formal process for tracking organizational cultural competence 	<p><i>Question: “How do you suggest understanding and meeting the health care needs of the diverse communities served?”</i></p> <ul style="list-style-type: none"> “A strong community organization would identify needs of the populations served. Whether it’s the Board of Health, or a school, or a school nurse who says, ‘My kids aren’t getting immunized.’ We have to get this population immunized. We need to get medical literature in Spanish or other text, because we’re not getting that message across.” (physician) “We have a very eclectic group (of patients): Spanish, Asians, Indians, Pakistanis, Koreans, Chinese, Russians, Jamaicans, and Africans. I think this practice really is a snapshot of that [central New Jersey demographics] but doesn’t provide us with the actual data.” (support staff)
Organizational Infrastructure	<ul style="list-style-type: none"> Inadequate staffing and technological resources 	<p><i>Question: “How do you see forging partnerships and dialogue with faculty, staff, patients, and the community that could help inform and promote CLAS-related activities?”</i></p> <ul style="list-style-type: none"> “We’re understaffed. There’s too much to do. Maybe we forget to give the doctors their phone messages right away, but you know it can get really busy some days.” (support staff) “We’ve had a lot of trouble with our phone system. You would think that the organization and the telephone company would be able to solve those problems.” (support staff)
Communication	<ul style="list-style-type: none"> No standard, uniform approach to culture and language issues 	<p><i>Question: “How do you see forging partnerships and dialogue with faculty, staff, patients, and the community that could help inform and promote CLAS-related activities?”</i></p> <ul style="list-style-type: none"> “I just use my own personal time to take part in health fairs and things along those lines. We had a church meeting, actually, where we went and just gave a talk regarding nutrition and basically talking to a population.” (physician) “But your question is more community health oriented. And that’s certainly not what I perceive happening within the business model we work in.” (physician) *Could apply to Governance Domain. “I don’t see you putting the cart before the horse. Until you create an environment that promotes serving of those patients, then you go out to the community and try and recruit. I would love to see more Latino patients. But I just hear how they’re treated at the front desk. What’s the purpose of doing that if you don’t feel you’re going to provide the best of care? (physician) * Could also apply to Governance Domain.
Staff Development	<ul style="list-style-type: none"> Lack of training in cultural competence and patient-centered care for clinicians and staff 	<p><i>Question: “What do you think is needed as far as cultural competence education for providers and staff?”</i></p> <ul style="list-style-type: none"> “We need training, lots of training. We need customer service training. We need to know more about medical care—the kind of problems our doctors take care of. We need to study our problems better. We need to understand them better. I think that problems need more than a simple response. Then we need to correct our problems in a good way, a way to serve our patients better, as well as our fellow workers.” (support staff) “No matter who they are or what culture, you’ve got to keep an open mind; listen to them.” (physician) “Why wouldn’t you have, if you’re in a business that wants to have your people back, why wouldn’t you have them smile at you? ‘Hello, how are you? How are you feeling today?’ Instead of, ‘Oh, what do you want? What’s your name? Give your card.’ Because they need to be instructed. They need to be taught that.” (patients)

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Table 4
(Continued)

Services/ Interventions	<ul style="list-style-type: none"> • Lack of culturally appropriate linguistic and educational resources. 	<p><i>Question: "How can we determine the most effective way to offer language assistance services to patients with limited English proficiency?"</i></p> <ul style="list-style-type: none"> • "Well as far as CLAS, I think it would be important to inquire either where the person was born or the language that they speak or are accustomed to using. And to have an interpreter available. I've had situations where a family member is present, and they really haven't done a competent job of interpreting . . . it should be an outside interpreter who is very competent in that language and in medical terminology." (physician) • "I've only had one problem here, and it was with the staff . . . I've come and they've canceled the appointment and claim they called my mother and the line was busy. My mother is deaf and blind, rarely uses the phone or leaves her apartment. I've asked them to call me and they don't. I've come here twice and she said, 'I couldn't get you.' And I said 'oh'." (patient) • "Well, we should have signs in their language, you know, right by the registration desk." (support staff) • "We're trying to be linguistically better to communicate with our patients, but we have patients from health care systems from throughout the world who come to the US and try to integrate into our system. So it's our challenge to meet them and their challenge to try to understand our system." (medical staff) • "One physician set up a Chinese phone line and has volunteers to translate her patients' questions in order to service their needs. Done entirely voluntarily. That's an extraordinary effort to meet the needs of her patients." (medical staff)
<p>* Examples apply to multiple Profile domains.</p>		

Governance (CLAS Standards 1, 8, and 9)

Participants reported the absence of organizational policies to support culturally and linguistically appropriate care. Lack of scheduled meetings to discuss service improvements for diverse patients signaled to many the unwillingness of leaders to develop new strategies or assume accountability.

Physicians were particularly concerned about inadequate policies for training students and residents about cultural competence. One provider commented about not knowing if the practice had done any assessment of CLAS, "I don't know if that's been done, but I don't think it should be by providers who don't have any power to convert that information to practice."

Patients felt that front desk staff should be more representative of different racial and ethnic groups and more responsive to their needs. The open access initiative at one practice was applauded and perceived as the organization's commitment to delivering more culturally competent care.

Communication (CLAS Standards 1, 4–7)

Language issues emerged among patients who lamented how they were sometimes treated by front desk staff. Their messages to doctors may not be delivered because front desk staff did not speak their preferred language. Patients shared examples of "coarse behavior," leading to perceived differential care due to

intercultural differences and limited English language capability. They recognized that physicians must probe deeper for answers with members of their ethnic group and feared that family members may not fully disclose symptoms because they will not be understood. They voiced concern that important health matters may be insufficiently addressed, although they were generally pleased with the care they receive.

Physicians' acknowledged that perhaps only 90% of their interaction with a non-English-speaking patient was effective. Several also expressed reluctance to increase their language skills and criticized lack of support for community outreach or relationship building.

Education (CLAS Standards 1 and 3)

The fourth major theme—Training and Education—fell into the "Staff Development" domain of the CLAS standards. The depth interviews and focus groups probed the question, "What do you think is needed as far as cultural competence education for providers and staff?" The data clearly indicated that medical directors and practice managers shared a common interest in enhancing organizational, provider, and staff cultural competence. While they expressed a desire to incorporate cultural competence into daily practice, resource limitations impeded effective communication at every level of interaction.

Medical directors expressed a need for ongoing training to improve knowledge and skills, as indicated by the response, “We don’t even know how to take a family history from different ethnic groups. We do it all the same way.” Office managers stated that “If you teach about cultures, you have to keep some general ideas, some general rule, or certain fundamental ideas about cultures. Where does the stereotyping begin, and where does cultural awareness begin? But I think there are some general principles . . . there are certain rules in a culture, and there are certain rules that you just don’t break . . . There are certain things you almost always do or almost always say because you know that facilitates [the interaction]. People appreciate that.”

Discussion

The depth interviews and focus group feedback revealed major frustrations relating to the care of diverse populations at two academic family medicine practices. Challenges related predominantly to delivery of linguistically appropriate patient services. This finding is consistent with studies showing that language barriers have a major effect on health care.²⁵ When physicians and other health care providers do not speak or understand the same language with fluency, the potential exists for misunderstandings such as inaccurate history taking, misunderstanding of therapies, and deferred medical visits. Lack of resources to support more culturally responsive care, organizational pressures, and multiple competing demands also inhibited preparedness to provide CLAS. The majority of respondents expressed a desire for learning more about cultural and linguistic competence.

Limitations

A number of methodological limitations of our study should be noted. First, it should not be assumed that participants were fully disclosing their personal views during interviews given the sensitive nature of issues relating to culture and diversity. Also, while the potential influence of association with a family medicine department and several faculty noted for expertise in cultural competency training and advocacy work related to CLAS may be seen as confounding, we argue that some exposure to the department’s cultural competence work yielded particularly information-rich data.²⁶

Second, all interviews occurred prior to a subsequent didactic series of cultural competency training sessions for the department’s health professionals, obviating any influence from the formal cultural competence education intervention. Third, one person moderated the focus groups, although some experts suggest that two are preferable—one with content expertise and the other with group dynamic skills. We opted for the latter to minimize participants’ reluctance to express

their views for fear of being “wrong” in front of the expert.²⁷

Fourth, we found the Profile somewhat complex for qualitative data analysis. Comments may apply to one or more domains, presenting difficulty in isolating cultural competence performance into a single, predominant category. For example, issues concerning language services might apply to “Communication” and “Services/Interventions” domains as well as their respective focus areas. We did not experience the need to “map” comments onto the prefixed domains. Rather, the Profile’s comprehensive focus areas provided substantial depth for the I/C analysis, allowing for ample reflection and insight regarding emergent themes as well as local change opportunities. Further, the potential for missing something that may not be perceived as significant (because it doesn’t immediately stand out) or central (because it too easily gets catalogued and forgotten) is unlikely given the discovery process that unfolds in the I/C methodology. The physician who voluntarily set up her own Chinese phone line to which only she responds was both significant and central, relative to perceived lack of resources that were countered by her dedication to serving patients’ needs.

Fifth, given the qualitative study design and small sample sizes, we caution against trying to generalize findings beyond our two practices. Larger-scale comparative studies involving multiple practices are needed using both quantitative and qualitative methods to determine the credibility and transferability of these results.

Future Directions

To our knowledge, this is one of the first organizational cultural competence research projects undertaken in academic family medicine practices. Developing organizational cultural competence is timely, relevant, and critical, given recent calls by accrediting bodies such as the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to attend to cultural and linguistic diversity, professionalism, and quality in medical education, residency training, and clinical care. Health care organizations are also attempting to address the Office for Civil Rights’ Revised Limited English Proficiency Guidance.⁴ National studies have been undertaken regarding “best and promising practices”²⁸⁻³⁰ relating to language service access, provision, and reimbursement.

It is noteworthy that in March 2005, New Jersey became the first state to require cultural competency training for physicians as a condition of licensure and to mandate that medical schools offer cultural competency classes.^{31,32} States currently considering cultural competency legislation include Arizona, California, Illinois, and New York.

Future studies are needed to (1) assess how family medicine academic practices are addressing communication barriers and providing language services to diverse populations, (2) obtain the views of residency program directors, residents, and medical students about culturally competent care, (3) assess the degree to which the Society of Teachers of Family Medicine Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care³³ are being utilized, (4) study the effectiveness of cultural competency training programs based on the CLAS standards,^{34,35} and (5) integrate cultural competency training into innovative quality improvement initiatives that assess patients' perspectives about culturally sensitive care^{36,37} and actively involve them as full participants in the process.^{38,39}

Increasingly, the business and quality case is being made for cultural and linguistic competence as a strategy to help reduce health care disparities.^{9,40} In the future, it is hoped that incentivized approaches will replace unfunded legislative mandates as a driving force for change. Our study has identified key areas where academic family medicine can take the lead in these important efforts.

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Appendix 1

Depth Interview Questions

I'd like to start by asking you to describe the population served by [practice site] in terms of its racial and ethnic diversity.

- What is the overall composition?
 - Have you seen a change in this mix over the past 5 years?
1. In terms of serving these populations effectively, could you tell me about any problems or barriers you have experienced?
 2. In terms of your experience at [practice site], can you describe any challenges you may have had with:
 - Providers and/or staff of culturally diverse backgrounds?
 - Patients and families of culturally diverse backgrounds?
 - Natural helpers and/or complementary/alternative medicine healers?
 3. We're interested in any success stories you'd like to share about your experience with cultural diversity:
 - Any that are practice-based that involve patients, providers, staff, vendors, natural helpers, and/or complementary/alternative medicine healers?
 - Any relating to the organization as a whole that involve patients, providers, staff, administrative personnel, and executive management?
 4. Please describe any policies or procedures you have been involved in developing and/or strategies and resources you have used in providing effective services to culturally diverse populations.
 - How do you know these were effective?
 - Is there any ongoing work you are involved with that addresses the needs of culturally diverse populations?
 5. Could you tell me your ideas about how and where key persons or groups within [practice site] might be able to collaborate to improve services to culturally diverse populations?

Adapted and expanded with modifications from the work of James L. Mason, JLM & Associates, Portland, Oregon 1994.

Appendix 2

Focus Group Interview Questions

1. How can physicians and other health care providers at [Practices A and B] ensure that patients receive effective, understandable, and respectful care that is compatible with their health beliefs, practices, and preferred language? (CLAS Standard 1)
2. What is the most effective way to offer language assistance services to patients with limited English proficiency? (CLAS Standard 4)
3. How can [Practices A and B] understand and meet the health care needs of the diverse communities it serves? (CLAS Standards 11 and 12)
4. How should [Practices A and B] self-assess current and ongoing organizational efforts to address the 14 CLAS Standards? (CLAS Standards 8-10)
5. What education and training would you and your physician/health care provider colleagues like to receive about culturally and linguistically appropriate services delivery? (CLAS Standard 3)
6. How can partnerships and dialogue with patients and the community help inform and promote CLAS-related activities? (CLAS Standard 12)