Cultural Competency and Linguistic Requirements and Services

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Why so important?

- Cultural competency is a primary ingredient in closing the disparities gap in health care.
- It requires a commitment from physicians, nurses, social workers, community health workers, other caregivers and all office staff personnel to understand and be responsive to the different attitudes, values, verbal cues, and body language that patients look for in their physician offices by their heritage.

Racial Health Disparities in the Philadelphia Area

- Latino/Hispanic populations have higher rates of asthma and diabetes
- Residents of North and Southwest Philadelphia have a far higher prevalence of ER visits than other nearby areas
- Black mothers are 3 times more likely to die from pregnancy-related causes than their white counterparts
- Black residents are 2.3 times more likely to contract COVID-19
- Latino residents are 1.7 times more likely to contract COVID-19
- Black and Latino pregnant women are 5 times more likely to have been exposed to COVID-19

LGBTQ+ Health Disparities

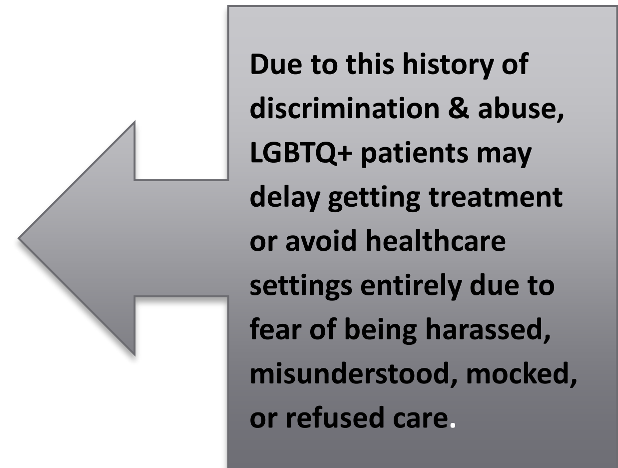
- Compared to straight/cisgender people, the LGBTQ+ community experiences higher rates of:
  - Minority stress
  - Depression
  - Anxiety
  - Substance use
  - Violence
  - Unemployment discrimination
  - Homelessness
  - Suicide

- Transgender and Gender Non-Conforming (TGNC) people experience more violence and discrimination than the LGBTQ community and are 7x more likely to contemplate suicide than the average population.

LGBTQ+ Experiences in Healthcare Settings

- **27%** of transgender patients have been denied care
- **50%** of transgender patients report having to teach their doctor(s) about transgender identities and health
- **70%** of transgender/gender nonconforming patients and **56%** of lesbian, gay, & bisexual patients have experienced at least one of the following:
  - Denied care
  - Doctors refusing to touch them or use excessive precautions
  - Doctors using harsh or abusive language
  - Blamed for their health status
  - Doctors being physically rough or abusive

Lambda Legal, *When Healthcare Isn't Caring.* (2010)



Cultural Competence

With growing concerns racial and ethnic disparities in health and about the need for health care systems to accommodate increasingly diverse patient populations, cultural competence has become a national concern.

Values, Beliefs, and Behaviors About Health and Well-being

- Shaped by
  - Race
  - Ethnicity
  - Nationality
  - Language
  - Gender
  - Socioeconomic status
  - Physical abilities
  - Mental abilities
  - Sexual orientation
  - Occupation
- These factors impact every individual, whether a patient, front desk staff, a social worker, a community health worker, a nurse, or the physician.

Culturally Competent Providers

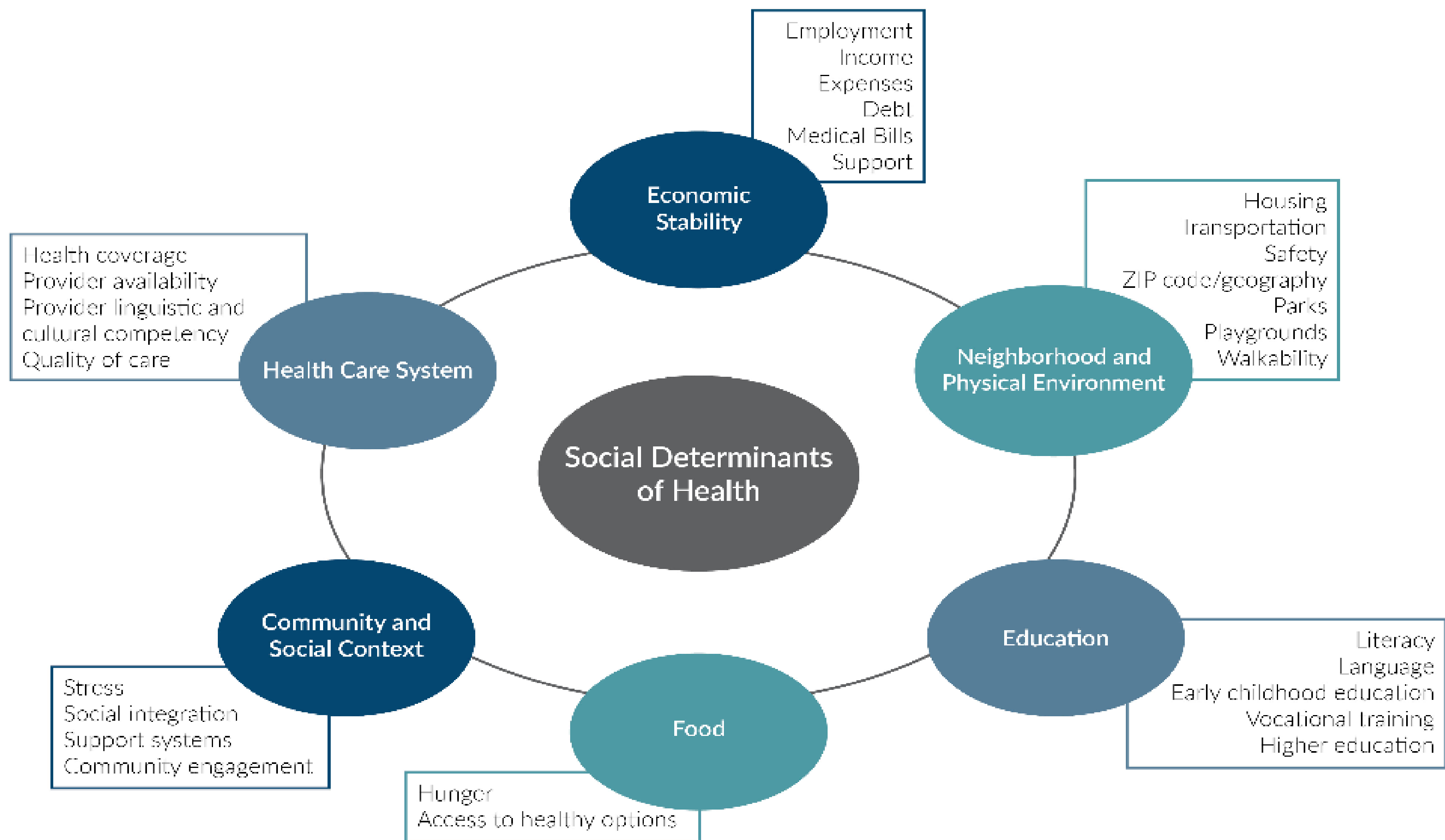
- Have the ability to
  - understand their own beliefs and biases, explicit and implicit
  - learn their patients
  - integrate these factors into their day to day provision of care

Cultural Competence

- Is the responsibility of everyone in the practice
- It is a process, rather than an ultimate goal
- Often developed in stages by building upon previous knowledge and experience
- The goal is always to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy.

Health Outcomes

- Medical care is a relatively small contributor – about 20% overall.
- Social determinants account for approximately 80% of a population's health outcomes.
- Our ability to understand and respond to the needs of the patients we serve has a tremendous impact.


Social Determinants of Health
Economic Stability
Employment
Income
Expenses
Debt
Medical Bills
Support
Neighborhood and Physical Environment
Housing
Transportation
Safety
ZIP code/geography
Parks
Playgrounds
Walkability
Education
Literacy
Language
Early childhood education
Vocational training
Higher education
Food
Hunger
Access to healthy options
Community and Social Context
Stress
Social integration
Support systems
Community engagement
Health Care System
Health coverage
Provider availability
Provider linguistic and cultural competency
Quality of care

Layered marginalized identities lead to compounded experiences of discrimination and inequity.

The Provider's Role with LGBTQ+ Patients

The practitioner's role when providing care to the LGBTQ+ community is to remember the following:

- Treat all patients with dignity and respect their identities
- Break the cycle of discrimination that creates barriers for LGBTQ+ communities to access healthcare
- Adopt best practices that are inclusive of and welcoming to LGBTQ+ communities
- Provide complete, unbiased, person-centered care that results in risk reduction and expanded access to resources and wellness for LGBTQ+ patients

National CLAS Standards

- Culturally and Linguistically Appropriate Services Standards
- Principle Standard
  - Provide effective, equitable, understandable and respectful qualified care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
- Governance, leadership and workforce
- Communication and language assistance
- Engagement, continuous improvement and accountability

Resources

- To help providers learn more about culturally and linguistically appropriate health care, Health Partners Plans recommends review of the following material:

  "*A Physician's Practical Guide to Culturally Competent Care*," sponsored by DHHS Office of Minority Health.

- This is a free, self-directed training course for physicians and other healthcare professionals with a specific interest in cultural competency in providing care.

- Continuing Medical Education (CME/CE) credits are available. Access the website at cccm.thinkculturalhealth.hhs.gov

HPP Provider Manual

Members have the right to receive services provided in a culturally and linguistically appropriate manner, including consideration for members with limited knowledge of English, limited reading, vision, hearing skills and those with diverse cultural and ethnic backgrounds.

Low English Proficiency

- LEP persons are individuals who do not speak English as their primary language and have a limited ability to read, speak, write or understand English.
- LEP is associated with poorer health outcomes among Latinx, Asian Americans, and other ethnic minorities across the United States.
- Less than half of the non-English speakers who say they need an interpreter during clinical visits report having one.
- The inability of providers to communicate with LEP patients leads to
  - more diagnostic procedures
  - more invasive procedures
  - overprescribing of medications

Provider Responsibilities

- Provide access to and assuming the cost for medical interpreters, signers and TDD/TTY services to facilitate communication.
- This includes at all points of contact and during all hours of operation.
- This is to ensure compliance with federal law and state contractual requirements that requires HPP Network Providers to provide language services to Limited English Proficiency (LEP) and Low Literacy Proficiency (LLP) members.
- This also includes members with sensory impairments.
- Provide members with verbal and written notice (in their preferred language or format) about their right to receive free language interpreters.

Provider Responsibilities (con't)

- Post and have printed materials in English and Spanish, and any other required non-English language requested by the member.
- Offer office staff cultural competency training and development.
- Provide care with consideration for the member's race/ethnicity, disability and language and how this impacts the member's health status.
- ***Make no assumptions about a patient's ability to understand English. All patients should be asked what their primary language is and provided with information on professional interpretation if that primary language is other than English.***

Who is a qualified interpreter?

- Patients should ALWAYS know that they have access to professional medical interpreters, including sign language interpreters and TDD/TTY services, to facilitate communication, without cost.
- Office staff wishing to complete professional medical interpretation training can learn more at www.quantumtranslations.com or by calling Quantum at 215-627-2251.
- Family or friends are not considered qualified interpreters and do not provide quality medical interpretation.
- Family or friends should only be used if the member insists, and the member has been offered free interpretation services, which they refused. The request and insistence to use family and friends' services should be documented in the patient record.

Types of Available Professional Medical Interpretation

In-person medical interpreters

Telephonic interpretation

Video conferencing

Provider offices can contact the HPP Provider Helpline to connect to the Language Line for telephonic interpretation, or Quantum for in-person interpreters or video conferencing.

Partnering with HPP
Medicaid Clinical Programs

- Culturally competent care and ongoing support to the membership are of the utmost importance to Health Partners Plans.
- Critical components include
  - Collaboration with a member, family/caregiver, health care providers and community agencies, as appropriate
  - Member-centric/whole-person focus
- Program objectives
  - Regain or maintain optimum health
    - Food as medicine program
  - Support provider's treatment plan and health care goals
  - Reduce or eliminate barriers to care
  - Connection to resources in the community for needs outside of the benefit package
  - Collaboration with BH-MCOs

What is a Special Need?

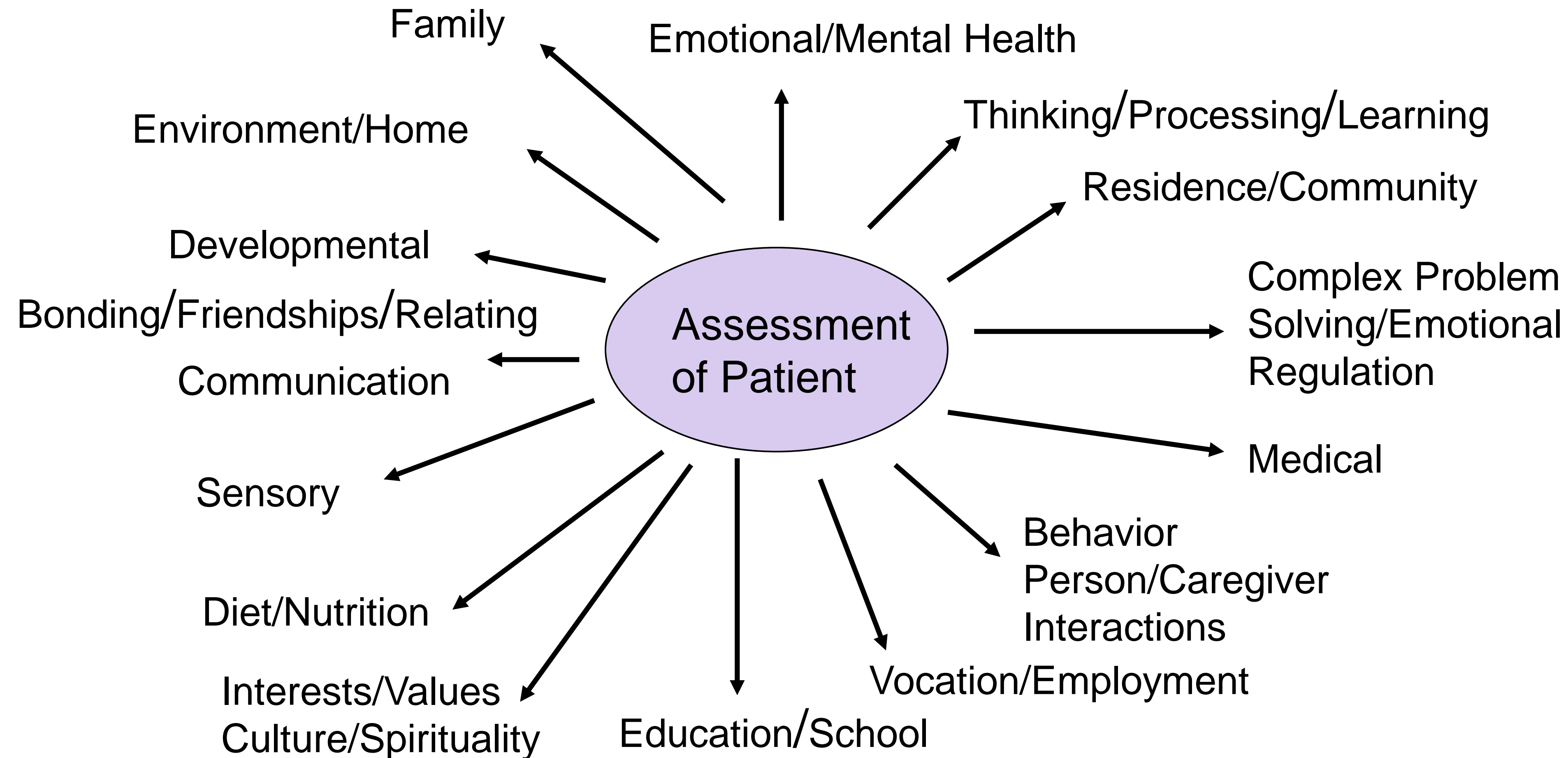
- Non-categorical
- Generic
- Inclusive, not driven by diagnosis
- Circumstances/situations/needs
- Anyone/anytime
- Short- or long-term

Members with special needs are assisted across our Clinical Programs teams.

Special Needs Indicators

- Birth defects
- Cancer
- Mental health issues
- Sickle cell anemia
- Visual impairment
- Hearing impairment
- Speech impairment
- Physical disabilities
- HIV/AIDS
- Substance abuse
- Intellectual disabilities
- Substitute care
- Wheelchair access
- Transportation
- Developmental disabilities
- Premature birth
- Domestic violence
- Traumatic brain injury
- Obesity
- Autism
- Homelessness
- Dental
- Family planning
- Other

Holistic Approach to Case Management



The Pictures that Tell a Thousand Words

AKA family care map

Medicaid Clinical Programs

Baby Partners

Clinical Connections

Complex Care Coordination

Healthy Kids

Special Needs Unit

Clinical Connections

Providers

- Provider referral line: **215-845-4797**
- Email referrals to ClinicalConnections@hpplans.com
- Fax referrals to **215-845-4181**

Members

- Clinical Connections Hotline: **215-967-4690** (prompt #1)
- Hotline answered by peer health coach during regular business hours and by a Special Needs Case Manager after hours, weekends and holidays.

Clinical Connections: Non-Clinical Staff

Peer Health Coaches

Triage member needs and refers to case management as needed

Responsibilities:

- Manage Clinical Connections hotline
- Post-inpatient discharge follow-up
- Health Risk Assessment (HRA) follow-up

Health Educators

Provide comprehensive, accessible education to members

Responsibilities:

- Tobacco cessation
- Disease-specific education

Clinical Connections: Clinical Staff

Dietitian Care Coordinator

- Registered dietitian nutritionist
- Works with members of all ages

Responsibilities:

- Nutritional counseling
- Provide education
- Develop member-specific meal plans
- Identify barriers
- Administer MANNA follow-up survey
- Community involvement

Broad Street Ministry

- Registered nurse onsite
- Collaboration between HPP, Broad Street Ministry, and Philadelphia FIGHT
- Focus on homeless/housing-insecure member population

Baby Partners

- Baby Partners provides comprehensive maternity care coordination for all pregnant and postpartum members, including
  - Ongoing case management nutrition counseling
  - Referral to and collaboration with behavioral health resources and services, including integrated care planning for members with SPMI
  - Doula services
  - Arrangement of skilled home nursing visits
  - Assistance with obtaining needed medical services before and after the birth
  - Linkage to smoking cessation, childbirth classes, MANNA (Metropolitan Area Neighborhood Nutrition Alliance) meals, and more
  - 24-hour breastfeeding helpline
  - Referrals to community resources
  - Transportation resources

Healthy Kids

- Healthy Kids ensures that healthy kids transition to healthy adults by utilizing the EPSDT (Early and Periodic Screening, Diagnostic and Treatment) periodicity schedule to provide collaborative and compassionate care to our members.
- The team provides targeted outreach and case management for members with the following indicators
  - Developmental diagnoses
  - Lead exposure
  - Substitute care
  - Neonatal Intensive Care Unit
  - Asthma
  - Diabetes
  - Attention Deficit Hyperactivity Disorder

Complex Care Coordination Program

- Social workers and nurses who are provider office embedded, field-based, and HPP-based
- Complex case management program targets the most complex adult members who are at the highest risk.
- NCQA driven program requirements for design.
- Telephonic outreach with home/hospital/facility visits as determined by the care plan.
- Letters are sent to members who cannot be reached by phone.
- Comprehensive assessment is conducted focused on health issues, utilization history, medications, social determinants of health and involvement with/need for community resources.
- Integrated case planning with the BH-MCO for members with SPMI.
- Ongoing case management interventions based on assessment findings and member-specific goals.

Special Needs Unit

- Case management and care coordination for
  - Adult members with moderate utilization patterns
  - Adult members with rising risk for complex health status
  - Pediatric members with complex medical needs
    - Many complex pediatric members require shift care nursing/home health aide services and/or medical daycare to remain in their homes

Coordinating Care with SNU

- Social workers and nurses who are provider office embedded, field-based and HPP-based
- Telephonic outreach with home/hospital/facility visits as determined by the care plan
- Assess members' individual needs, including social determinants of health
- Primary purpose: coordination of care, access to care and linkage to community resources

Coordinating Care with SNU

- Provide ongoing case management services, including integrated care planning with BH-MCOs for members with SPMI
- Coordinate with multiple providers to improve communication
- Liaison with schools and community agencies
- Assist with the transition to adult care for members aging out of EPSDT

Coordination of care