

## Culturally Competent Care: Some Examples of What Works



Roberto Clemente Center

# **Culturally Competent Care: Some Examples of What Works!**

**A study and report by the Commission on the Public's Health System, Inc., in partnership with the Brooklyn Perinatal Network and The Bronx Health Link.**

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Judy Wessler, Director of CPHS, was involved in every aspect of this effort. Ms. Wessler is directly responsible for the visits and tours to the nine health care networks and for the writing of this report.

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Several people were involved in administering the surveys, including: Anthony Feliciano, Camille Howard (volunteer), Rosa Geraldino (student intern), and Lois Hunter (volunteer). Peter Cheng, Executive Director of Indochina Sino American Community Center administered the surveys in Chinese. Maha Attieh, Health Advocate at the Arab American Family Support Center, administered the surveys in Arabic.

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## **Executive Summary**

Culturally Competent Care: Some Examples of What Works! is a follow-up study based on work done by CPHS and its' coalition partners in a Child Health Initiative. This city-wide effort surveyed 659 parents in twelve languages about their children's health and access to care. The survey showed many cultural and linguistic barriers in access to care for children.

CPHS teamed up with two organizations – the Brooklyn Perinatal Network and The Bronx Health Link – to look at what cultural and language components work in different provider health care settings. A literature review showed features of this study that distinguish it from others: surveying people to help define cultural and language competence; presenting the analysis of the survey data to a Policy Committee; and using the review and the data to develop a survey Checklist to review facilities and interview health care providers.

The survey was administered to 117 people in four languages at community-based organizations. Findings from the survey include: access to care was difficult due to language and/or socio-economic barriers; a lack of respect from providers due to race differences; people who are undocumented can only receive care in the Emergency Room. A Cultural Checklist was developed incorporating these findings to be used to interview and tour provider sites.

The health care provider sites visited were chosen from recommendations by community organizations, based on their

reputations for providing culturally and linguistically competent health care services. There were common themes found in each of the provider sites that are listed in the Introduction section of this report.

This report contains a summary of the visit to each of nine health care providers networks visited under the categories: Knowing the Community; Language and Cultural Competence; Best Practices; Weaknesses; and Access Issues. Special specific attributes of each of the providers is also described. The providers described in this report may not be the only ones who are culturally and linguistically competent in the services they provide, but they are excellent examples of how services can be organized to meet the needs of the community.

Recommendations: In order to focus on keeping people healthy and providing services in communities, many of the important practices identified in this report need funding. In multi-ethnic, multi-cultural communities, these provider sites are an important model that should be emulated in many other communities. State and federal funding must be made available to ensure the continued viability of this critical safety net. The community-based health networks are large-scale providers of services for the under- and uninsured. The state government must ensure that public funding is properly allocated to facilities that provide services to these populations. The federal agencies responsible for implementing the new health reform law need to work with community organizations and community-based providers to fund this critical safety net.

## **Introduction**

Work done by the Commission on the Public's Health System (CPHS) in 2008, in coalition with community partners, resulted in two important reports<sup>1</sup>, that laid the groundwork for this project. The coalition, the Child Health Initiative, organized events to celebrate the 100<sup>th</sup> Anniversary of the city's Child Health Clinics. As a part of this Initiative, borough coalitions interviewed 659 parents in twelve languages about their children's health status and their access to health care services, as well as 114 young people in 12 focus groups. Among other important findings, results of the survey showed many cultural and linguistic barriers in access to care for children.

Following up on these critical findings, CPHS proposed a study to look at what cultural and language components work in different provider health care settings. CPHS teamed up with two organizations to do this study that had served as borough coalition leaders in the Child Health Initiative – Brooklyn Perinatal Network and The Bronx Health Link. Both key staff people at these organizations have substantial experience in working on cultural competence issues.

The first step was a literature review to determine what studies had been done, how they were carried out, and what the findings showed. Nine studies were reviewed to

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<sup>1</sup> *Voices from the Community*. and *Yes New York Can!* Commission on the Public's Health System. December 2008.

learn their methods and outcomes. The seminal work was done in 2002 by a team that reviewed the medical literature, and interviewed experts in government, managed care, academia, and community health.<sup>2</sup> The team visited model sites and lessons learned included:

- Integrate components of cultural competence into different aspects of the educational curriculum.
- Integrate new initiatives into existing structures and collaborate with federal partners to increase funding support.
- Use publicity and market influences to stimulate development of culturally competent services, employ a multicultural staff and establish a multicultural advisory board.
- Form partnerships with community-based organizations, establish a governing body that provides feedback, and develop a vision and mission statement that aims for high levels of patient satisfaction, good clinical outcomes, few barriers to care and relationships with community groups.

Another major study was performed by The Commonwealth Fund through a randomized computerized phone survey concentrated in

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<sup>2</sup> Betancourt, Joseph, Alexander R. Green, and J. Emilio Carillo. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. Rep. Print.

minority neighborhoods.<sup>3</sup> The most common forms for gathering information included: site visits, focus groups, and telephone surveys.

## Methodology

Several features were incorporated into this study to distinguish it from others reviewed on Cultural Competence. This study relies on surveying people to help define cultural and language competence; presenting the analysis of the survey data to a Policy Committee that had been working on the Child Health Initiative; and using the review and the data to develop a survey Checklist to review facilities and interview health care providers.

The goal of this study is to learn what features made people feel comfortable, culturally and linguistically, in a health care setting. Several steps were taken prior to visiting provider sites:

- To define competence in these settings, CPHS and their two partners designed a survey to learn from people themselves about the positives and the negatives they are confronted with when going for a medical visit.
- 117 people were interviewed by CPHS staff and trained interviewers

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<sup>3</sup> Johnson, BA, Rachel L., Somnath Saha, M.D., MPH, Jose J. Arbelaez, MD, MHS, Mary Catherine Beach, MD, MPH, and Lisa A. Cooper, MS, MPH. *Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care.* Journal of General Internal Medicine 19 (2004): 101-10.

at community-based organization sites, in four languages (English, Spanish, Chinese, and Arabic).

- The data from the survey was analyzed and the results presented to the CPHS Child Health Policy Committee for their comments.
- The findings of the survey were used to develop a Cultural Checklist survey form. The Checklist was designed in four parts: Overview questions; Language competence; Cultural competence and comfort issues; and Other issues identified in the survey.<sup>4</sup>
- The Policy Committee, and other community organizations, was asked for their recommendations about providers that would meet the criteria developed.
- Interviews were set up with health care providers in all five boroughs. Prior to the visit, the Cultural Checklist was sent to the person to be interviewed.
- An interview was held and a tour of the facility was conducted. Judy

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<sup>4</sup> Issues identified by patients during the survey: the need to have a primary doctor; being treated with respect; walking into a friendly place; being encouraged to be involved in one's own patients care decision-making; days and hours of service based on the needs of the patients; respecting a person's immigration status; a diverse staff that reflects the community; having a mechanism for community and patient involvement; and having a grievance process that is culturally and linguistically competent.

Wessler, CPHS Director, did all of the interviews and tours.

- A draft write-up of the interview was sent to the person interviewed to review for any inaccuracies.

### **What the Survey Showed**

CPHS believes that responses to surveys are different when administered by someone who resembles the person being surveyed, which was the case for these interviews by an African-American woman and a Latino man. We also believe that there is a trust level because the questions and answers are occurring in a community setting where the person feels comfortable.<sup>5</sup> The strength of the responses to the open-ended questions, tended to confirm this assumption.

Characteristics of those surveyed:

- 75 of the 117 respondents were Hispanic/Latino; 17 were Black/African American; 2 were Caribbean; 12 were Asian; 5 were Arabic-Speaking; 6 Other.
- 79 of the 117 respondents were foreign-born.
- 26 of the respondents spoke English at home.
- 83 were women, 34 were men.
- Over half of the respondents (68) had income less than 25,000
- 39 (1/3) of the respondents had no health insurance.
- 32 respondents received their care at a hospital clinic; 29 at a private

doctor's office; 17 at a community health clinic; and 22 at a combination of places.

- 45 respondents stated that health care was difficult to access.
- 78 responded that evening/week-end hours would be more convenient for them.
- 42 respondents said they felt that race/ethnicity plays a role in the treatment they receive – based on their skin color, poverty, and immigration.

Perceptions of Problems found on the survey include:

- Access to care was difficult due to language and/or socio-economic barriers.
- There was a lack of respect from providers due to race differences.
- People who have private insurance receive better care.
- People are treated as a number and not as a person.
- Waiting times are long and the visit with the doctor is rushed.
- People who are undocumented can only receive care in the ER.

### **Development of Cultural Competence Checklist**

The Cultural Checklist form incorporated the concerns/questions/barriers raised in the survey. The form was field-tested in English and Spanish. There are four subsections of the survey questions: Provider Overview Questions; Language Competence; Cultural Competence Comfort

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<sup>5</sup> CPHS experience with the 659 surveys done for *Voices from the Community*. 2008.

Issues; and other important issues identified in the survey.

### **The Health Care Providers**

The health care providers highlighted in this study were chosen because of their reputation as serving their communities in a positive way that is culturally competent and linguistically competent. Each provider site will be described individually but there are also common themes and attributes that were present in most, if not all, of these health care providers.

The common themes that we found in the provider sites visited can be identified in three large categories: Community/Patient Interaction; Accessibility; and Cultural Competence Practices.

#### **Community/Patient Interaction** includes:

- Community Assessment/review to identify the patient population, residents not using the services, and identifying changes and new populations.
- Outreach into the community and special programs relating to populations/illnesses.
- Efforts to involve the patient, and the family, in decision-making in their own care.

#### **Accessibility:**

- Have a sliding fee scale for uninsured patients, which is made known to patients.
- Have evening and/or week-end hours.

- Have staff people who speak the languages of the patient, or have interpreters available or provide access to a language line, to care for patients who speak a primary language other-than-English.
- Have access to interpreter services for the blind, hearing impaired, and disabled.

#### **Cultural Competence Practices:**

- Best practices identified by the providers interviewed of cultural competence and language competence.
- A diverse staff, reflective of the patients and the community, is hired at all levels, and is often hired from the community.
- Many staff are bicultural/bilingual, and are native speakers.
- Doctors/nurses and other staff have learned to listen to patients and to learn from them. They are open to racial and cultural differences and how to address them.
- Recognize the race and ethnicity of health care providers and acknowledge that patients are attracted when the race/ethnicity/language of providers reflect the community.
- Recognize the differences and problems facing new immigrants and develop treatment/efforts to recognize differences based on the length of time spent in the U.S.
- Friendly and respectful treatment of all patients.

- Decorations and colors used on the outside and the inside. Have pictures/paintings/colors of walls/etc. that reflect the cultures of the community. Signs, posters, information are translated into the common languages in the community.

The survey included two additional questions in the Language Competence section that are not referenced in the write-up for each provider, and deal with interpreter services to accommodate the blind, hearing impaired, or others with disabilities. All of the providers interviewed have some agreement for interpreters to be available if arrangements are made 24 hours in advance of the persons visit. However, it did not appear that these providers have many requests for these services. Some questions should be raised, although not in this study, about where people with disabilities are going for their health care services.

**The Health Care Providers (listed in alphabetical order)**

The nine health care providers highlighted below may not be the only providers that are culturally competent and linguistically competent in the health care that they provide. These sites were chosen based on information available about them, and recommendations from organizations with which we work. Sites visited are located in all five boroughs and in diverse communities. The sites visited:

- Charles B. Wang Community Health Center in Flushing, Queens
- Community Health Center of Richmond on Staten Island
- Roberto Clemente Center, Lower East Side, Manhattan
- Lenox Health Center and the Medina Clinic, Harlem, Manhattan
- Ryan-NENA Community Health Center, Lower East Side, Manhattan
- Montefiore Family Health Center, Bronx
- Lutheran/Sunset Park Family Health Centers – Caribbean American Family Health Center and the Park Ridge Family Health Center – Brooklyn
- Urban Health Plan Health Center, Bronx and Plaza Del Sol Family Health Center, of Urban Health Plan in Corona, Queens.
- Webster Houses Child Health Clinic, Bronx

## **Charles B. Wang Community Health Center – Flushing, Queens**

Interviewed: Betty Cheng, Chief Operating Officer, and Amy Shek, Administrator

The Flushing center is part of the Charles B. Wang Community Health Center (CBWCHC) located in Manhattan. This center occupies three and one-half floors of a five story modern building. One floor houses the administrative offices and facilitated enrollers, one floor is devoted to OB-GYN, another floor has pediatric services, and the final floor has adult medicine and some specialty services. The center is clean, bright, and decorated in warm colors.

**Knowing the Community** – The center periodically does a community assessment and knows its population is recent immigrants. Since they know their Chinese population, the assessment focuses on the Korean community. There are private Korean doctors in the community, but they don't accept Medicaid for adult patients. The center has some Korean speaking staff, but does not have a doctor who speaks Korean. There are some Spanish-speaking and some African American patients. One of the Chinese doctors also speaks Spanish, which has attracted some Spanish-speaking patients. Through a health fair with a Nepalese association, the center provided services and learned about that community. Community assessments are done on a systems level by staff at the main center in Chinatown.

**Language & Cultural Competence** – The center does cultural training for the staff. There are lots of differences within the Chinese community, so it is important to incorporate these differences. There are some basics that are taught: “must have basic decent respect for everyone. If smile to someone can communicate good message.” Don't assume just ask – teach me. I won't know about your culture so well but need to know you as a human being.” It is also important to ask about the person's use of herbal medicines. At registration, patients are asked what part of China they come from, what dialect they speak, and the time of their immigration to check for different illnesses.

One thing the center tries to do is not to be too “Chinesey” of an environment. There is a space for a mural on the third floor that is waiting to be filled. They try to do posters in Chinese, English, Korean, and Spanish.

Ninety-eight percent of the front line staff speak Chinese, they are basically native speakers and know the different dialects. Sometimes it is a problem with staff that do not speak English well, but they are encouraged to learn more so that they can deal with outside organizations. There are different languages/dialects in Chinese, but Mandarin is the most common language in this community, along with Cantonese and Fujinese. When needed, the ATT Language Line is used for interpreting, but that does not often happen – the language line is used under ten times a month for the entire CBWCHC. There is no formal interpreter training for staff, although the center will be

starting a Certificate Program for Interpreters with City College of New York. The doctor has to know how to use the interpreter. Informal assessments are used by supervisors to assess the quality of interpreting. The center has back-up and referral agreements with two hospitals, Flushing and New York Hospital of Queens. Depending on what area in the hospital the patient goes to, they have to wait for interpreters. The Family Health Workers make special arrangements for interpreters for patients using specialty clinics.

Written communication is an issue as there is traditional and simplified writing in Chinese. The older generation uses the traditional writing. People who learn simplified do not understand traditional writing. Written materials must be bilingual and culturally relevant and meet the reading level of the population. The center is constantly updating the written material which is prepared by a retired physician with the most current information.

**Best Practices** – “The best practice is knowing, understanding, and learning about the patient. Getting to know the patient as an individual, not a disease.” The center has a patient relations staff committee with one person from each department. There is a patient suggestion box on each floor, which is checked every day. The committee talks about complaints/comments and a response is given in three days. The staff also does outreach in the community, with education and screening. Staff members participate in other organizations. The YMCA is three blocks away and the center works with them

on joint events. They have an obesity team for overweight children and incorporate taking them to the Y to promote exercise.

**Weaknesses** – The center has some turn-over of staff and hiring of new staff becomes a weak link. There is a need to acculturate new staff. Staff members are asked to identify their ongoing training needs.

**Access Issues** – Each patient has a primary care practitioner (PCP). The center has nursing, nutrition, and social workers to support patients. They accommodate patients who don't care if they have their own PCP, particularly for walk-in appointments. To increase access to services, the center is open seven days a week from 8 am to 6 or 7 pm. There is also a 24-hour on call service. If a patient is Korean-speaking, there is a Korean translator.

The center does not push immigration questions and everyone is seen regardless of their immigration status. If the person does not have health insurance, they are asked to verify their name, address, phone number, and date of birth. There is a sliding fee scale and a person can self declare their income. Six percent of the patients at this center are uninsured, and it is 15% in both sites.

The center has a friendly atmosphere. Staff people are reminded to treat people with respect, and wear a button that says “promote good experience.” Respectful treatment is stressed during orientation as meeting the mission and goal of the center for the population they serve.

## **Community Health Center of Richmond (CHCR) – Staten Island**

Interviewed: Henry Thompson, Chief Executive Officer

Mr. Thompson just started at the center in November 2009. The initial services were developed by the city's Health and Hospitals Corporation in response to community and elected officials pushing for public health services on Staten Island. The interview was conducted in the administrative offices which are across the street from the health center. Although there is newly constructed expansion space, it is very crowded. Another new facility is being built down the street which includes two floors with six dental operatories on the second floor. Part of the health center is being redecorated so that women's and children's services are now in the same area. One of the nice touches is the children's scales are in the shape of animals.

During our tour of the health center, a pregnant woman in the waiting room stopped Mr. Thompson, calling him by name and complaining to him about having to wait too long to see the midwife. It was impressive to see the comfort this patient felt in stopping the Director to complain and knowing his name.

**Knowing the Community** – A comprehensive assessment was done which looked at a number of things, including the demographics of who is using the services. The assessment is being used for strategic planning by the board and administration.

The patient population is primarily English and Spanish speakers. Some patients are from Liberia, the Latino patients are from South and Latin America. There are also some Mexican patients who speak Mixteca, a dialect.

The population of Staten Island has changed since the opening of the Verrazano Bridge which connects the Island to Brooklyn. There has been an increase in persons of color and immigrants living on the Island. People describe this a AB and BB – before and after the bridge.

**Language & Cultural Competence** – At least 80 percent of the staff are Spanish speakers, and most are native speakers. Many staff members are hired from the community and are able to walk to work. All written materials are translated. The center uses a language line primarily for the social worker for about two to three hours a week. Other staff can also serve as interpreters. There is no formal training for interpreting at the center, and no evaluation of the quality of the interpreting. However, Mr. Thompson said that problems with interpreting would come to his attention.

The center does an annual training and cultural competency is a part of it. Through Staten Island Hospital there is also a course on health literacy that includes cultural competence. One patient would end up in the Emergency Room when her medications ran out because she did not understand the meaning of the word "refill." CHCR has a contract with a community-based organization to provide sign language

services, but this is not being requested. The exam rooms are also labeled in Braille. CHCR provides one level of care for everybody and sponsors or participates in community events

**Best Practices** – In all key areas there are individuals who can interpret for patients. Translating forms into multiple languages is a common practice. Two nurses and several doctors are Spanish-speakers. Staff are used as role models for each other. When Mr. Thompson started at the center, he did an ice breaker session. He said that he made staff feel comfortable because he started the session talking about himself and stressed that everyone has hidden talents and needs to understand what things people are good at. Much of culture is based on family concepts and staff is encouraged to embrace patients like a family. The culture of the organization is to “look at how we treat each other and have respect for all people.”

**Weaknesses** -- Weaknesses were not described.

**Access Issues** – CHCR is open during the hours that are convenient for their patient population. Two days a week the center is open from 8 am to 8:30 pm, and two days a week the center is open until 10 pm. On Saturdays, the hours are from 8 am -12:30 pm.

A satisfaction survey of 192 patients was recently completed, which provided good baseline data. The survey was designed by an outside company which also analyzed the

data. Patients were asked how they feel about their care and if the doctor listens.

Each patient has an identified primary care doctor. The center has Patient Navigators to assist patients. They also have clinical people who follow-up on lab results, hospitalizations, and medications.

The registration process is used to collect demographic data for the center. No one is turned away. Patients are asked for identifying information, but are not forced to produce all information. If patients won't come for care at the center, there are bodegas along the street where people can go instead to buy medications. At times convincing people to come in for health care services requires a lot of outreach. The center participates in events with their business partners such as the local pharmacy. Some of the events are done to recognize different holidays CHCR is working hard to be visible in multiple communities.

As a Federally Qualified Health Center, CHCR has a community governing board that is representative of the community. The board has committees that are actively involved in the center and its operations. Soon after this visit, CHCR was organizing a strategic planning retreat with the board and administration.

## **Roberto Clemente Center, Manhattan**

Interviewed Dr. Jaime Inclan, Executive Director

The Clemente Center was created in 1984 as a result of advocacy efforts of many people. The center is the first mental health program in the State where all staff is bilingual and bicultural, treatment is oriented to families, is located within the community, and service is oriented by a service/academic model.

When you approach the Clemente Center, culture is splashed across the outside walls (see cover picture). The mural painted by Chico, a Lower East Side muralist “represents the mixing of Latin American cultures, races, and identities up to the current period of immigration in North America.” Art work inside is also representative of the Latino cultures. This is seen as a way of welcoming people and identifying with them. The center is on one floor and well-designed.

The center provides primary care and mental health services. The interview was about the mental health services, which focuses on family health and community health.

The center has a training program. There are 4 psychology interns, 5-6 social work trainees, and 2 marriage therapists. When trainees leave, their caseload is transferred to permanent staff or to a new intern. Emphasis is placed on patients identifying with the center, rather than a provider that may change.

**Knowing the Community** -- A survey is not done, but the center collects and reviews data and they know the ethnicity of patients who come in for care. They know where patients are referred from. 44% of patients are Puerto Rican, 20% Dominican, 10% African American, 7% Mexican, Central and South Americans are 4% each. The languages spoken are English and Spanish. Chinese patients from the community are not coming for care. There are patients from Yemen who are coming to the center for primary care.

**Language & Cultural Competency** -- All staff members are bilingual, bicultural native speakers. There is a good sense of who is being hired because they train at the center. All written materials are translated.

There is a training program for staff that includes basic family therapy seminars and within that they will talk about immigrant families. There are studies that were written by center training faculty which are used in the training. All of the training is imbedded in understanding of families in their cultural context. Training on cultural competency is done within the training program for all staff.

This is a family-oriented clinic. Students in training come from different continents to get exposure to family centered care. Every new intake is presented for case discussion and a psycho-social evaluation is done. Clients are included in decision-making.

The different races of patients are acknowledged at every level. It is true of

the staff composition. Roberto Clemente was a Black Puerto Rican man who strived to excel, to help others, and for social justice. Sylvia Villard is the name of the other Clemente program, and she is an Afro-Puerto Rican American woman who dedicated her life to honoring African roots in Latin America.

**Best Practices** -- Therapists need to be aware of immigration information when working with a patient. This information is asked at the initial interview. Recent immigrants are different, with different values and expectations – so be aware of the stages of the psychosocial integration process of immigrants. Speak the language of the community. Dr. Inclan recommended “Be an anthropologist and don’t think that you know – observe and know the difference between practice and conceptual ideas that you might have.”

**Weaknesses** -- In mental health, the healing effect is the result of an interpersonal emotional transaction, not due to chemicals in medicines reacting in your system. The agent of change is communication and the center pays absolute attention to facilitating it.

**Access** -- The primary care unit at Clemente serves Clemente patients and the general community. Office of Mental Health regulations require that all patients receiving mental health services have an annual physical. The center aims to do comprehensive care for all patients that do not have a primary care doctor.

Respect for patients is not just person-to-person, it is also recognizing and honoring different cultures. There is a poster in the reception area painted by a man from Puerto Rico with flags from all of the South and Latin American countries. There is also a painting in the waiting area that represents African heritage. The clinic was set up based on the philosophy “provide care as one would expect to receive it oneself.” Dr. Inclan said that the need is to restrain front desk staff from becoming over-involved and over-identified with patients needs and to promote their kindness and respect toward others. Most staff people live in the community. Another rule is that patients be seen at the appointed time – that is a statement of respect in a treatment center.

The hours of service are Monday to Thursday from 9 am to 8 pm, Friday until 3 pm. “You can’t be family-oriented and have clinic hours only in the morning.” Everyone is expected to work two evenings a week.

The center is a part of the Health and Hospitals Corporation and treats everyone. The question of immigration is built into the model of care, but is not put in the chart. “We look at immigration phases as stages, and how people are oriented rather than what country people come from.”

The community is involved through a cross-referral network. The center evaluates what organizations might be of assistance to a person. Staff people participate in some community organizations.

### **Lenox Avenue Health Center/Medina Clinic/Renaissance D&TC**

Interviewed: Dr. Elliott, an internist in the Lenox Clinic. Dr. Zafar, the Director of the Medina Clinic. By telephone, Dr. John Palmer, Executive Director, Harlem Hospital.

The Lenox Avenue Health Center is a satellite community site of the Renaissance Health Network and Harlem Hospital Center. The Medina Clinic is a special program within the Lenox site set up to provide services for Muslim patients from West Africa. The center is across 116<sup>th</sup> Street from a large, active Mosque. About five years ago, Dr. Palmer started looking at center utilization and how to improve cultural competence. He reached out and had meetings with Mosques in Harlem. He found that of the 50 people from Senegal invited for lunch, ten needed medical care and one had to go to the Emergency Room. Dr. Palmer searched for grants to address the needs of the West Africa/Senegalese population and was able to obtain a two year foundation grant. The Medina Clinic is held on Fridays at the Lenox Health Center, and on Saturday at the Harlem Hospital Ron Brown ambulatory center.

The Lenox Center is on West 116<sup>th</sup> Street and has a large visible sign posted outside. Entry is through a small lobby and one flight up on an elevator. The elevator opens up into a waiting area that is sparsely furnished with a reception desk, a security desk, and chairs for patients. There is a large table on one side with some health information. The

hallways leading to the examining rooms are decorated with art work and posters that reflect the different cultures of patients attending this clinic.

**Knowing the Community** – Dr. Elliott said that an assessment is done of patients coming to the clinic for service. The Medina Clinic was set up because more West African patients were coming to the clinic. Patients are attracted to services based on who is providing the care. Dr. Elliott is from Jamaica, BWI, and said that when he moved from one clinic to another, his Caribbean patients followed him, and that “people follow a doctor they feel comfortable with.” A few years ago there was recognition of a growing Spanish-speaking population in the community so some Spanish-speaking staff members have been trained as interpreters. If an interpreter is not available, the doctors use CyraCom language line. The dominant languages are English, Spanish, French, and Wolof. The dominant ethnic and cultural groups are Latino and West African.

Dr. Zafar said the leadership of the hospital put the Medina clinic together and it was philosophical as to who should be on the team. Dr. Zafar is a Muslim woman who is a Family Practitioner and understands the religious culture of her patients. Initially she visited mosques and hair salons to let people know about the clinic. The clinic is focusing on new immigrants and how to bring in the whole family for care. People coming to the clinic have had symptoms for ten or more years. When asked they will

claim they have no problems and no pain until they are touched and it is painful. People need a lot of care and many are just surviving. Dr. Zafar said that she had to teach people what is meant by a refill of medications. They also looked for community resources, such as for food and shelter, so the clinics could make referrals for help. The clinic is working with local community organizations, including the African Services Committee.

**Language & Cultural Competency** – Dr. Elliott said that Lenox has had several training sessions over the years. To determine what to focus on in training, they look for the barriers faced by patients. There is ongoing cultural training, particularly about the West African population and Spanish speaking cultures. Dr. Elliott said that he learns about culture from his patients. One patient, an elderly West African man was found to have diabetes. He was taught how to inject insulin, but his wife felt threatened by his use of the needle. The man wears protection against evil spirits and his wife was afraid that the needle would affect his protection. The man's treatment was adjusted and he no longer uses insulin, and is carefully monitored by Dr. Elliott. Harlem Hospital has an interpreter training program and people are certified after the training. Dr. Elliott uses CyraCom when examining patients whose language is Wolof. Using staff to interpret is preferable, and the language line is less personal and its use requires him to keep his questions very straight forward – you also miss the body language and the smiles. The

quality of interpretation services by staff is assessed by staff at Harlem Hospital. Written materials are available in Spanish and French. “When the HHC clinics work right, they are the best kept secret in town.” But it is a problem to deal with culture when you have too many patients.

Dr Zafar said in West Africa, culture is culture plus religion, because there are religious barriers. There is a feeling of alienation in the Muslim community, particularly post 9/11. The Medina clinic has medically certified interpreters, which is required by Harlem Hospital, and the clinic has all languages available including Wolof. Dr. Zafar also teaches medical students and has developed a course on West African health issues.

**Best Practices** – Dr. Elliott said that the use of CyraCom is good because there are no barriers. “You can't give care without interpreters.” Patients want to be spoken to respectfully. There is a system in place and patients know who to complain to, and they do.

Dr. Zafar said that there is a full-time interpreter in the Medina Clinic and a Patient Navigator. The Navigator accompanies the patient and attends to many non-medical needs which is important in the population. All staff work together as a team. There has been an increase in patients so Dr. Zafar has asked for a Nurse Practitioner or Physicians Assistant to work with her. When patient referrals are needed, they use the Electronic Medical Record and there is no problem. She also sees patients

at Harlem Hospital when they come for appointments.

**Weaknesses** – Dr. Elliott said that they cannot know about the cultural mores of all countries. There is a lack of knowledge about other cultures. “You have to be prepared to learn from the patients.”

Dr. Zafar said that word spread about the clinic in the past year and there have been enormous amounts of new patients. Medina staff people give patients their cell phone number so that they can contact the provider. For six months, Dr. Zafar had a lot of time with patients, before the number of patients coming to the clinic grew. Instead of changing the way that they practice, they try to limit the number of patients. It now takes a couple of weeks to get an appointment, but spaces are left to get people in when it is necessary. Dr Zafar screens patients to determine when there is need for a quicker appointment.

**Access Issues** -- Dr. Elliott is a primary care doctor. Each patient has a primary care doctor. The care delivered is patient-centered and patients are involved in their own care. Lenox has evening hours, but no services on week-ends. Lenox is affiliated with the Sydenham clinic on 125<sup>th</sup> Street which has services on every other Saturday. As a public clinic that is part of HHC, the services are open to all patients. There is no question about treating people regardless of immigration status. The clinic works to involve the community. Patients are invited in for community programs and information,

such as about AIDS and diabetes. There is a Renaissance Community Advisory Board.

Dr. Zafar said that the clinic has built up a population of 600 patients within six months time. There are two sick slots for each day to ensure that people in need can be seen quickly.

## **Montefiore Family Health Center, Bronx**

Interviewed: Claudia Robinson, Nurse Manager and Alfonsina Perez, Health Educator. A follow-up phone conversation was held with Dr. Zac Rosen, Medical Director.

The center is in its own three-story building in a residential community. The reception area is small and the pharmacy, run by an outside company, is right in the same area. There is an elevator to the second and third floors where the examining rooms are located. There are some specialty services provided on site; for the rest of specialty care, patients are referred to Montefiore Hospital. However there is a long waiting time for many of the specialty services, e.g., neurology is three months. There are special slots for Medicaid and sliding fee scale patients. Ten percent of the patients at this center are uninsured.

The center trains residents on-site. The residents are assigned for three years and the program is heavily continuity oriented – the residents are assigned on the same days each week. In total there are 38 family practitioners. Some of the residents do home visiting.

**Knowing Community** – There was an assessment survey done by the health education department to see what patients would like to know more about. There is no formal community assessment done, but some residents have done projects. The center knows the community resources that are available.

The major languages spoken in the community are Spanish, French, Vietnamese, and Cambodian. There are also Egyptian patients who speak Arabic.

**Cultural & Language Competence** -- The center has doctors who speak French, Spanish, Vietnamese, and Haitian Creole. One of the managers speaks several African dialects and can communicate with West African patients.

The residents placed at the center are assigned for three years and don't come on Tuesdays or Saturdays. There are between 10 and 18 doctors present at any given time. The residents take a course in Spanish and medical terminology. There are 4-5 nurses who speak Spanish, and one who is a Cambodian speaker. There is no interpreter training for staff and the center does use the language line when needed. There has not been a formal assessment of interpreting skills, but the center is working with a Southeast Asian task force of community-based organizations to determine how they want to do an assessment. One of the community organizations had filed a civil rights complaint and is now part of the Task Force.

The staff reflects the community but do not have interpreter roles. Rather they are used to supplement the language line – which is done using speaker phones.

The center tries to accommodate the cultural requests that patients have. For example, Muslim women want a woman doctor.

Spanish speaking patients prefer a Spanish speaking doctor.

Patient education is provided in different languages. For instructions on medications, people are taught in their own languages. Pharmacy labels are in English and Spanish. There will be a training session on the Cambodian culture. Staff have visited Cambodian and Vietnamese temples. The center co-sponsored a lecture at the public library with the Coalition Against Asian Violence on “Justice is Healing.”

The center has an all Latina Women’s Group that meets with a psychologist. The same women have been attending the group for years. They talk about their lives and about supporting each other. The group members are self-identified.

Written materials are translated by an outside company, and most are done in 5 to 6 languages.

The center has multi-cultural photographs in the halls that were taken by Dr. Rosen.

**Best Practices** – The center believes it is best to accommodate a person with a person who speaks their language or use the language bank. The center uses a speaker phone in exam rooms for language interpretation. Also, the center will have interpretation for incoming calls for the Vietnamese patients. When referred to the hospital, a language line is used for interpretation. The receptionist takes out a universal language booklet so that the patient will specify their preferred language.

The center offers acupuncture services. They have a Zumba class one evening per week, where they clear out the waiting room for use as a dance floor. The health educator spends time in the reception area doing presentations and cooking lessons. They have an electric grill and a blender that can be transported to the reception area. A DVD is being prepared for the waiting area that will show what services are available at the center.

Having a diverse staff creates the cultural atmosphere so that everyone is treated fairly and in the same way.

**Weaknesses** – The majority of the patients are Latino and African American. Sometimes the center does not have staff that speak a certain language, such as Albanian. There are certain languages that patients speak where they will use a language line.

**Access** – Every effort is made to have patients see their doctor. There are same-day or 48 hour (two days) appointments available in each doctor’s schedule. Otherwise it can sometimes take two to three months for an appointment. The center is in the process of becoming a “patient-centered medical home” so they have health education and a psychiatrist on site.

In staff meetings the concept of having a friendly face is continually reinforced. Patients are encouraged to file a complaint if there is a problem, which is reviewed by customer services and is investigated.

Originally, the center was open late two nights a week, but more patients needed evening appointments, so they are now open every evening Monday to Thursday and on Saturday when feasible.

The center is open to treating immigrants. They get new arrivals from all over and some come without documentation. For people without documents, the administrator approves seeing the patients and works with them on how to get documents. If people are not able to get insurance, they are placed on a sliding fee scale until they are eligible, based on income and family size. There is a discounted fee in the pharmacy and patients pay \$5 for prescriptions.

The Medical Director and two social workers meet with Asian community organizations. There is a half-time staff person that addresses the issues that are common to Vietnamese and Cambodian residents. There are volunteers from the CAAV Task Force that help guide the center on programs. The center would like to hire a Patient Navigator but does not currently have the resources.

**Ryan-NENA Community Health Center,  
Manhattan**

Interviewed: Kathy Gruber, Executive Director; Carmen Quinones-Veneski, Director of Patient Services; Victoria Gonzalez, Community Relations Coordinator; Marlene K. Ford, Director of Operations.

The center is located in its own six story building. The interview took place in the sixth floor board room. There are attractive decorations on each floor. The elevator is used to communicate education/information with signs posted in three languages – English, Spanish, and Chinese. The staff at the reception desk is very friendly and helpful. The dominant languages spoken in the community are English, Spanish, Chinese (Mandarin, Cantonese, and some Fujinese). They also have some Hindi and Russian patients.

**Knowing the Community** – The center does an assessment annually, where they look at the numbers and see what the trends are. They also do Patient Satisfaction Surveys. Since St. Vincent’s Hospital closed, former patients are being referred to NENA, so they are tracking the patients that are coming in. NENA has a list of about 100 patients that are enrolled in Fidelis HMO and who were reassigned to NENA for ongoing services.

**Language & Cultural Competence** – The center has core competency training done annually and by different managers. Several times during the year they also do an

orientation, which is done as a group. Staff are told to be mindful of patient’s cultures. They have some Muslim patients and the men don’t want to be examined by a woman doctor. They also train staff to be sensitive to age differences, and to watch the elderly.

About half of the health care providers are Spanish speaking. Some are fluent and some know a little. The provider will get a staff person who speaks Spanish to help interpret. The staff are not trained interpreters, but they will indicate when they don’t feel comfortable translating. NENA does not have a formal way of assessing the interpreting skills. All patient materials are translated into Spanish and Chinese.

Assessments of the cultural backgrounds of patients are done by the nurse and followed up by the doctor. The center wants to know the patients family status and what barriers the patients face. This is done annually, or more often if the staff notice a change to be followed-up. Patients are asked how they define themselves racially and culturally. There is a questionnaire as part of the clinical visit where the patient is asked their preferred way of learning. The staff will also verbally go over the Patients’ Bill of Rights. Respect for people of different races and ethnicities is part of the center – Ms. Gruber said: “it starts on day one, it is part of who we are.”

There is a community bulletin board on race and ethnicity in the lobby and people stop and read it. In patient education material, the center uses pictures of people who look like the patients’. It is only at Christmas

time that they have holiday decorations for the three holidays. Some of the art work that is up was created by patients. Sometimes the center has patient education sessions on different topics, sometimes held in the department and at other times in the lobby.

Cultural competence training was done for the entire staff in the last two years. The center does an annual staff satisfaction survey and asks staff members what kind of training they would like. Staff members often request cultural competence and customer training. The training is done by an outside company.

The center has repeat customer training skills. If there is a problem, the situation is brought to the supervisor, and then if not resolved, to administration. Respect for patients is stressed when people are hired and also in orientation for new staff. They learn how to deal with patient anger. Staff people are told that “everyone plays a role in making patients welcome to the center.”

**Best Practices** – There is evidence throughout the center that says you are welcome here. The brochures and educational materials reflect the culture of the community. There is an openness from the top down --- from board to leadership to management team. The message has to be reflected in the everyday practice. It is important to see and understand the diversity of the patients. Staff members will ask for an interpreter for a person who is coming in for an appointment.

Ms. Gruber said: “They have had providers say this is a desirable place to work because they are exposed to so many cultures.”

**Weaknesses** – Sometimes they do not have a person on staff that speaks the language of the patient, but they do use a language line. The provider and the patient have to speak and then pass the phone for the interpreting. This is not the best way for communicating. It is only used about 10 to 15 times a month.

**Access** -- Many patients have managed care and a consistent doctor. The center makes it feel like a ‘medical home.’ If children come in, they also register the parents. NENA has specialty services on site. For back-up services, patients are referred to their back-up hospital, Beth Israel, where they see a private doctor and are not sent to clinics. The hospital has hospitalists in the ER to coordinate care and have “one-stop shopping.” Uninsured patients that are referred to the hospital have to go to financial assistance and they are fee-scaled.

NENA has adopted the Joint Commission on Accreditation of Health Organizations to “Speak Up” campaign. It is posted in the elevator and is meant to encourage patients to ask questions. There are also efforts to involve the family in discussions. There is a recognition that sometimes patients feel more comfortable talking to front line staff than to the professionals, as the front line staff are from the community and are recognized. The staff then encourages the patient to raise the issue to the doctor or nurse. If this doesn’t happen, the staff can raise it directly to the doctor.

NENA is open two nights a week, on Mondays and Thursdays, until 7:30 pm. It is open on Saturdays from September until June. The center does a review of how many appointments there are and may add providers. For example, provider hours for the podiatrist have been increased because more patients are going for this service.

If a new patient does not have insurance, they are referred to the financial staff, and will be asked for information about identification and a social security number which is now required by federal agencies. The center has a policy that no one will be reported.

The center looks for people with language skills when they are hiring new staff. Many staff members speak Spanish. The center is now looking for people who speak different Chinese dialects as they are seeing more Chinese patients. Information and materials are available in three languages: English, Spanish, and Chinese.

Ryan NENA is part of the William F. Ryan Community Health Center Network. There is a community governing board for the network, which includes Ryan/NENA patients. Patients are involved in focus groups. The center is now working more on diabetes, and a walking group was developed along with a nutrition program for patients that was developed with the Cornell Cooperative Extension program. There is an HIV community advisory group which meets quarterly. Staff members also have relationships with patients and have encouraged involvement in advocacy

efforts, such as the Revlon Run/Walk and going to Albany with the staff for Advocacy Day.

## **Lutheran Medical Center/Sunset Park Health Center**

Interviewed Virginia Tong, Vice President for Cultural Competence at Lutheran Medical Center. Visited two of the ten health centers with Ms. Tong. The Caribbean-American Family Health Center with Dr. David John, Medical Director. Toured with Ms. Tong, Park Ridge Family Health Center, with Ivan Cortes, Site Director and Theresa Deweil, RN.

Ms. Tong is Vice President for the overall corporation, which includes the hospital and the ten health centers. Ms. Tong has a budget for her department and was able to develop policy that all documents that go to patients are reviewed for language, culture and health literacy.

**Knowing the Community** – Ms. Tong started at Lutheran/Sunset in 1995 and was hired to do outreach and marketing in the Chinese community. She started a cultural advisory committee.

Lutheran Hospital does strategic planning and that determines where to focus efforts. The dominant languages in the community are: English, Spanish, Chinese, and Arabic. There are all different dialects of Chinese. There is a sprinkling of people who speak Haitian Creole because of one of the health center sites. The Health Council for the Sunset Park Health Centers is multi-cultural and so is the board of the hospital. Ms. Tong also has six advisory boards representing different groups, including Spanish, Chinese, Arabic speakers, disabled, and

Lesbian, Gay and Bi-Sexual, and Transsexual. With a community-based organization, an Arabic community health survey of 350 people was conducted; going to mosques, hookah bars and other places to interview people. They found that lots of people are uninsured and use the emergency room for care. Most of the people surveyed are Egyptian. Work needs to be done to outreach to these communities to provide information about using the health centers. A survey had been done in the Chinese community and found people were going to Chinatown for health care, which is why Lutheran developed a family practice site for the Chinese community.

**Language & Cultural Competency** – Lutheran/Sunset Park uses the Center for Immigrant Health to do Medical Interpreter training. They also had an intermediate Spanish class. There is an assessment of language skills when people are first hired. Fifty to sixty percent of encounters are in a language other than English. There are over 200 people available, depending on the language and the shift, capable of interpreting, and they are located throughout the system. Interpreter training is voluntary. They also have a language bank.

In 2004, there was a full day of training provided by the Center for Immigrant Rights. In 2007, there was a half-day session. There is department-specific training upon request, which is specific to the issue or the titles of staff. There is lots of staff training on respect of different

cultures. There is on the job specific training by job title on customer service.

The development of how one asks the person's preferred language was part of a process. They now use: "Which language would you prefer to use when talking about your health care?" There has also been an expansion of how ethnicity is looked at, it is not just Puerto Rican, but also includes Ecuadorian and Mexican cultures. The Family Health Center's patients were primarily from Puerto Rico, but now is Mexican patients. They revised all of the Spanish translations. They have done focus groups to define words that everyone will understand. They use the traditional Chinese, which is what newspapers use.

Understanding different cultures is done through assessment, training, and bringing in community groups to do presentations and assist with trainings. There are holiday celebrations and an effort to not leave anyone out as people are proud of their culture. Lutheran/Sunset Park celebrates about 30 holidays. Staff can get a group together and organize a celebration; they are provided with money for food. The celebrations take place in the lobby of the hospital. The celebrations are always done for two hours during the lunch time.

There is now a mosque that is right next door to the chapel. 85% of the Arabic speaking patients are Muslims.

**Best Practices** -- The existence of the Cultural Competence office, as Ms. Tong is at the VP level, has her own budget, and she

reports directly to the President. The mission statement says "our only purpose for being is to serve the community." There is leadership and support from the multi-ethnic board of trustees and the health council. The centers hire from the community and are sensitive to the other different cultures. Ms. Tong said there is a culture of respect for different cultures. She is open to getting advice from other people and does so through an advisory structure that also includes focus on LGBT, senior, and disabled communities.

**Weaknesses** – There are no resources to do everything they want to do. There are also still pockets of resistance amongst the staff even though there is a "big stick" strong support from the administration. There is a lack of a pool of bilingual professionals. Councilwoman Sara Gonzalez is helping with funding for a bilingual nurses program.

**Access** – Patients have an identified primary care doctor. Every effort is made to match the language and culture of the patient and the provider. There are social work medical assistants that help with care. There is a WIC program. Behavioral health services are centralized, and family counseling services roam between sites. The hospital/centers have school-based health services. They also just picked up 22 homeless sites that were formerly run by St. Vincent's Hospital. There are lots of different ancillary services. They do not just provide health care services, as they have day care services, English as Second

Language training, and job training as part of the hospital.

Sunset Park has about 90,000 registered patients, and over 500,000 visits. Health Plus is their managed care plan and they are available at most sites to enroll people. They have been told by staff and patients that Lutheran/Sunset is a friendly place. Ms. Tong said the place has a terrible lay-out, so when people ask for directions, they are often walked to where they need to go. The culture of the organization is that people walk you everywhere because it is difficult to direct them. There is a multi-cultural security guard staff that sees themselves as navigators. They had a conscious effort to find Arabic, Chinese, and Russian speaking guards, working with the media and community organizations to find people.

Most immigrant families don't come for care by themselves, so as much as possible they include as many people as can fit in the exam room. At the Caribbean and Chinese sites, there is open access without appointments because people are not used to making appointments. The hours of service are scheduled based on the cultures of the community – at the Chinese site it is open Sunday through Friday.

Ms. Tong said the health centers don't ask about immigration status. People are asked to apply for health insurance. Some sites have more self-pay patients than others. About 25% of patients overall are self-pay. The Caribbean site is about half self-pay.

### **Caribbean Family Health Center –**

Initially, this center was a joint project with the Caribbean Women's Health Center. Discussions are ongoing about the operation of the center. The languages spoken here are English, Haitian Creole, Spanish and French. The hours of operation are Monday-Friday 8 am to 8 pm and 8 am – 4pm on Saturdays. There are 33,000 visits per year and about 11,000 of them are diabetes related. Dr. John, the Medical Director, said the clinic is driven by how the community views health care. They treat generations of the same family. Some of their patients go to private practitioners for specialty care. Those who are uninsured are referred to Lutheran Hospital for specialty care. About one-third of their patients have no health insurance.

### **Park Ridge Family Health Center –**

There are 4,500 registered patients, with 39,500 visits last year. Fifteen percent of the patients are uninsured. The clinic has 20 exam rooms, and a dental area downstairs. Because of the population and the staff, there is an Islamic prayer room. The clinic often sees 30 walk-ins per day. There are medical assistants on staff ready to interpret in Spanish, Albanian, Arabic, Russian, Chinese, Urdu, Hindi, and Bengali. Mr. Cortes said the clinic's culturally relevant service sets them apart from other clinics. Arabic patients prefer to contact their doctor on his cell phone. Mr. Cortes meets with community leaders on a regular basis.

## **Urban Health Plan/Plaza Del Sol Health Center, Bronx and Corona Queens.**

Interviewed Ivy Fairchild, Chief Development Officer. Helen Arteaga, Director, Plaza Del Sol Health Center.

The new site in the Bronx is large, with several floors. The facility is bright, colorful and laid out beautifully. There is a skylight and brightly painted walls. There are tropical Caribbean paintings and other interesting wall hangings, including a picture of Dr. Carmona, former U.S. Surgeon General and Sonia Sotomayor, now a Supreme Court Justice. Both of these officials were patients at Urban Health.

There is a focus on being healthy, including having food demonstrations done in the lobby of the building to promote healthy eating. The center also participates in a food distribution program. There is a physical therapy room and they also have a Wellness Program that includes a special work-out room for patients and employees to use. There is a contest for employees to see who can lose the most weight. We met a young staff person that had lost 80 pounds.

In the Bronx, in 2009, there were over 37,000 patients and 200,000 visits. This capacity will be doubled with the opening of another new building. There are 402 staff members including 70 health care providers. In addition to primary care services, 20 specialty care services are offered, along with ancillary and diagnostic services. There are health education services and

support for patients with asthma and diabetes.

Ms. Fairchild said: “At the end of the day, staff has to believe in what they do. The leader communicates to the staff and staff is invested in the place.”

**Knowing the Community** – Three years ago, Urban Health Plan did focus groups at all of its sites. The feed-back was positive and they found that patients were satisfied with the level and quality of services. Urban had an annual patient survey, which is now done every month by an outside company by telephone. The information is viewed by all departments, and for example, they look at waiting times and make adjustments. Urban Health uses a PDSA methodology—Plan, Do, Study, and Act – as a model in the change package. There are charts that outline the Plan and Action on the walls throughout the center.

The dominant languages in the community are English and Spanish. A majority of patients are Puerto Rican, and some are from Ecuador and Guatemala. About seven percent of patients at the Bronx center are uninsured.

**Language and Cultural Competency** – The center has had trainers who come in to talk about cultural competence and it is also addressed during orientation. The center does customer service training, which started with the receptionists and front desk people. There are patient advocates that can help patients. There is a “survival guide” manual for staff with all of the policies

clearly listed – it is small and manageable for staff.

Most staff is Latino and from the community. There are very few staff people that don't speak Spanish and almost all are native speakers. The center spends money recruiting Spanish speaking doctors, including from out-of-state. Most staff people are promoted from within. Some staff came in as Medical Assistants and are now LPN's. The center has paid for some staff to become nurses. There is a learning center that provides staff with classes, on-line and on-site which is free. There are computing classes. Except for ESL classes, time off is granted for classes.

Each doctor is assigned a Medical Assistant who can translate if the provider staff do not speak the primary language of the patient. The staff are not trained in interpreting. All written materials are translated.

Provider meetings are held every Tuesday. One issue they deal with is that lots of patients practice alternative medicine, so the medical director wants staff to be aware and knowledgeable about these practices. There is a push for a relationship with healers. These meetings are used to remind providers about cultural differences.

There is no structured way of acknowledging the different races of patients. The center organizes an annual San Juan Fiesta which is their signature event and is a way of thanking the community, and where all departments show

case their services. 2,500 patients attended this year.

**Best Practices** – Hiring staff locally to reflect the composition of the community works. It is necessary to be mindful of written material. Translate everything and have people from different communities review the material. Urban Health often has to translate materials into Spanish.

The center believes in dealing with people as people not as color and race. Ms. Fairchild said: “This is what our staff is trained to do. That's how we operate.”

**Weaknesses** – For translation of material, they have to go through a gamut of review. It can take a long time. For example, it was hard to get swine flu posters out in a timely manner.

**Access** – Everyone who comes into the center gets a primary care physician. Urban Health has special designation as a “Medical Home.” Some patients and doctors have been at the center for 25 years. Some patients have seen the same doctor for years. The center started turning patients away who just come in for specialty care. There is now a three month waiting list for dental care. Referrals are made for follow-up care to Bronx Lebanon, Lincoln, and some to Montefiore.

The atmosphere at the center is very friendly. It is really like a family. Patients come in early and sit in the waiting room and talk to the staff. Patients and board members act as volunteers, such as manning

an education table in the lobby downstairs to provide health education.

The center is at capacity and is open seven days a week at the main site. The center is open from 7 am to 7 pm five days a week, on Saturday until 3 pm and Sunday until 3 pm. A large immigrant population comes in on Sundays, when the center sees about 120 patients. The center has an urgent care clinic that is utilized by patients when they are not feeling well on that day. The doctors all have access to the medical record on the computerized system.

The center treats people regardless of immigration status. They do require a picture ID. There is a sliding fee scale for all inclusive visits. There is a pharmacy plan – 340 b – with reduced out of pocket costs. Urban Health has a Facilitated Enroller on site to help patients apply for public health insurance.

Patients are given a self-management goal. Diabetics, for example, meet with a nutritionist and set goals. There are health educators in every department.

There is active involvement of board members and patients. Board members sit at health education tables. There are eight patients who are volunteers and they get trained in chronic disease management. There is involvement in all areas of the organization.

**Plaza Del Sol Family Health Center, Corona Queens** – Helen Arteaga, the Director, opened this center a little over a

year ago, after several years of planning. In the first year, the center doubled the number of patients they had projected to serve. The center is in a very attractive building that inside and outside uses Caribbean colors. Anywhere you go in the center you see a sun on the floor tiles. The center has six suns which are representative of the Hispanic culture and their respect for the sun god. It is a cultural recognition of the origins of most of the patients.

The staff is warm and welcoming. Patient advocates walk around speaking to patients in an encouraging manner, asking if they need help. People are hired for this position based on having certain qualities that are looked for. The center treats primarily people of Latino origin from Ecuador, Mexico, and the Dominican Republic. Forty-seven percent of the patients are uninsured and pay on a sliding fee scale. There are some African American and East Indian patients. One of the physicians speaks Spanish and Bengali which is a draw. The clinic's staff is bilingual and bicultural, and 70% are hired from the community. Many walk to work.

The center provides patients with a case manager who makes it a point to take thorough patient history, including social and home conditions, food, and housing. There is a social worker available to families on Tuesdays and Thursdays. The immigrant patient population sometimes has a hard time acculturating and the social worker can help.

The center contracts with a company that regularly calls some patients after a visit to check satisfaction levels and to look for areas of improvement. The current satisfaction level is 89%. The center uses E-clinical works software to maintain all patient information in an organized and confidential manner. The software alerts nurses with color-coded boxes on the screen to monitor all patients and assists doctors just by looking at the computer screen, this creates less room for error.

Ms. Arteaga lives in the community. Her father died from cancer because he had no insurance and had not been treated. She said that it became her dream to set up a health center in Corona. There was an initial attempt to work with North Shore/Forest Hills Hospital which did not work. Urban Health Plan was willing to work with her to open this center. The center has affiliations with Forest Hills and Elmhurst. Referrals back and forth work well. However, Elmhurst Hospital is so busy that there is a six month wait time for an appointment for some specialty clinics.

## **Daniel Webster Houses Child Health Clinic, Bronx**

Interviewed: Dr. Angela Sanchez

The Child Health Clinic is part of the Health and Hospitals Corporation's Generations Plus Network. It is located in the Webster Houses development of the New York City Housing Authority. There is a large sign posted outside in English and Spanish. The inside of the clinic looks well-used, is clean and probably needs a paint job. Dr. Sanchez is a pediatrician who has worked at this health center for 21 years. She works here three days a week and somewhere else two days a week. Two Fridays a month Dr. Sanchez spends at the affiliated Morrisania Diagnostic Treatment Center seeing patients.

The examining room that Dr. Sanchez uses is papered with pictures of her patients. She pointed proudly to those of her patients who are now in college. One of her patients just got a full scholarship to go to Columbia. Dr. Sanchez said that she does not use the examining room where the computer screen would interfere with her looking directly at the patient.

Two days a week there is no doctor at this clinic, so there is fear that the center will be closed on those two days. There was a short period of time where Dr. Sanchez did not work at this clinic. Community residents got together a petition to bring her back. Dr. Sanchez appears to be a local treasure in this community.

**Knowing the Community** – Of the four staff people that work at the Webster clinic, two speak Spanish, which is the second dominant language in the community. Dr. Sanchez said she sees Mexican, Dominican, and Africans, as well as Puerto Rican patients. Recently some of the new patients coming to the clinic are from Gambia. They can communicate, but there is no interpreter. The language line is not used because the clinic has old rotary phones, making it very difficult to make these calls. The patients are asked to bring someone with them or to give a name and phone number of someone who can translate for them.

**Language & Cultural Competence** – The staff at the clinic are diverse and match the community. Two of the persons on staff speak Spanish. The clinic needed a new nurse because the one that had been there for five years recently left. Dr. Sanchez did request a particular nurse as a replacement. Dr. Sanchez said she is lucky with the staff as they are efficient and friendly. Her assistant knows everyone and remembers everyone's names.

Written materials and consent forms are in Spanish and English. Some of the health information materials in Spanish come from the other clinic that Dr. Sanchez works at two days a week.

Dr. Sanchez has been at Webster for a long time and she gets involved with the families and the grandmothers. She has been to five wakes of patients families. If a child is sick, she will call the grandma to ask how they are doing. She treats everyone with respect.

Dr. Sanchez knows who the “frequent flyers” are – the people who come in even though they are not sick. Eighty percent of the children that she sees are asthmatic.

Two Fridays a month, Dr. Sanchez sees patients at the Morrisania D&TC. She knows the patients and knows their problems, so they want to be seen by her. Patients that she has seen at Morrisania transfer to Melrose so that she can continue seeing them.

**Best Practices** – The best way is to listen and learn from your patients. For example, patients will talk about their home remedies and Dr. Sanchez does not discourage them because many have worked for years, but she does also encourage patients to take the medicine that she prescribes. She tells the patients “do your remedies and do the medicine.” “Listen to learn and learn to listen.” Dr. Sanchez gave an example of an Ecuadorian woman who was concerned about her child’s ‘pupita.’ She had no idea what the woman was referring to but by listening and pointing to different parts of the body she was able to learn that this was a word for belly button.

Dr. Sanchez has seen two generations within families and there is a comfort level with her.

**Weaknesses** – Dr. Sanchez said there are not too many weaknesses. There was a problem when a doctor who did not speak Spanish worked at Melrose on the two days a week when Dr. Sanchez was not there. If there is no staff in the clinic, there is no

answering machine and no information for people about where to go when the clinic is closed.

**Access** – The clinic is open five days a week from 8:30 am until 4 pm. There is a doctor present only two days a week.

The clerk in the clinic interviews patients and asks the questions, and is very good at handling all issues including immigration status. Dr. Sanchez said she does not know the status of any patient and everyone is treated the same.

There was a time when the Child Health Clinics were part of the Department of Health. There was no charge for services. The clinics had Public Health Nurses that would make home visits and really get involved with families and the community, and would know where to refer patients with a social or other problem. This is no longer true.

## **Conclusions and Recommendations**

Culturally Competent Care: Some Examples of What Works!, documents the provision of culturally competent and linguistically competent health care services in nine health care networks. In addition to the surveys completed for this study, CPHS and its Child Health Initiative partners, interviewed 659 parents in twelve languages and heard from them that often the missing piece in the care they received was being able to feel comfortable and respected. Clearly, the need for culturally and linguistically competent care is of primary importance to the many people that we have surveyed and interviewed about this issue.

What distinguishes this report from others addressing this complex issue is that we asked the community directly about their opinions and perceptions concerning their care. To provide a thorough picture, we also asked what made them feel at ease culturally and linguistically in a health care setting. Surveys were conducted at community-based organizations where people were chosen at random and asked if they would participate. These sites do not provide health care services. They do provide services for low-income, immigrant, and persons of color. One-hundred and seventeen surveys were completed and these responses were then used to develop a Cultural Checklist. The checklist provided objective criteria that formed the basis for the interviews and site visits with health care providers. All these steps indicate a clear reliance on community involvement at all

levels of the development, implementation, and final results of this study. We relied on their suggestions and opinions and this report is a testament to this process of engagement.

One might ask why is this process necessary. Research, best practices, and just plain old common sense indicated that culturally and linguistically competent care is important to meet the health care needs of communities. What we offer in this report is proof that there are dedicated providers who are accomplished in providing this care. One limitation of this report is that we did not evaluate their success rate in providing care, but we do know from published studies that community-based providers have excellent records of reducing the use of Emergency Rooms and preventing unnecessary hospitalizations; in short in providing care that prevents complicated illness, lost wages and undue stress.

Recommendations:

We recommend that a follow-up study could look at the cost-benefit of providing competent care as a way of avoiding more costly medical care.

The report also indicates that it is imperative to ensure additional funding for safety-net providers to pay for any additional costs involved in providing culturally competent care, such as for trained interpreters and patient navigators or advocates.

State and federal funding must be directed at safety-net providers to ensure their

continued viability as the United States moves toward more expansive health insurance coverage. Community-based public and private health networks are large scale providers of services for Medicaid patients, and the under- and uninsured. This critical infrastructure must continue to be viable to ensure that access to care can continue and grow as more people become eligible for coverage, and others are left out of the insurance system.

There is a strong need for local, state, and federal government to work with community organizations and community providers to fund the safety-net and maintain and expand culturally and linguistically competent care.

The method used in this project, developing criteria based on community consultation, should be adopted by others doing similar types of studies. The community based participatory approach should be incorporated into all phases of research.

There have been demonstration projects (e.g, the Community Health Care Conversion Demonstration Project (CHCCDP) where funding was available to improve the provision of primary and ambulatory care services. In order to gauge the benefits and outcomes of these types of demonstrations, it is important to fund work similar to this study to evaluate the changes in other ambulatory settings. Part of the evaluation would include the ability of these health facilities to provide culturally and linguistically competent care.