Paterson-Passaic County – Bergen County
HIV Health Services Planning Council
City of Paterson Bergen-Passaic TGA Ryan White Part A Program

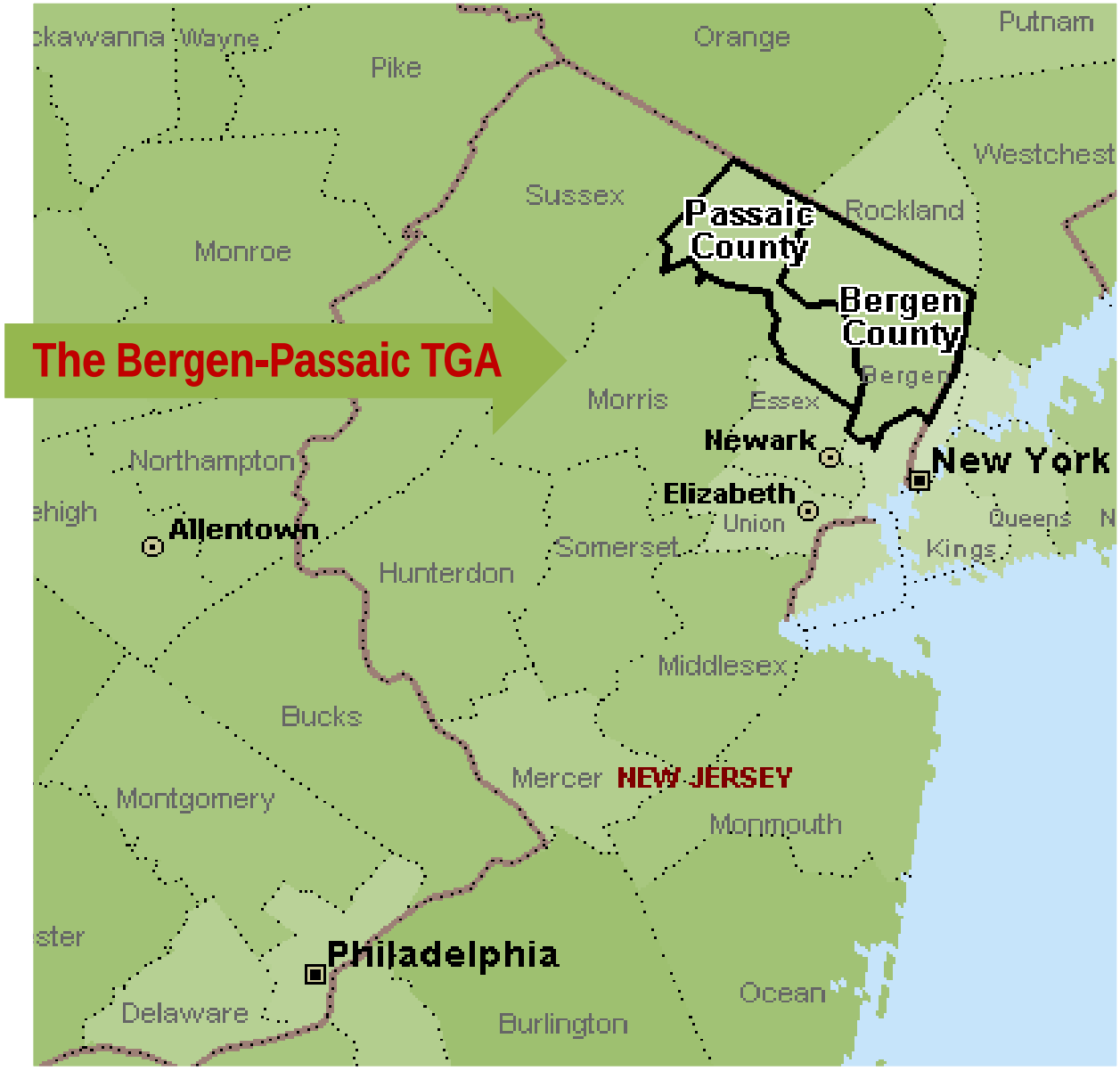
CREATING A CULTURE OF COMPETENCY:
CHALLENGES AND APPLICATION OF CULTURAL COMPETENCY STANDARDS

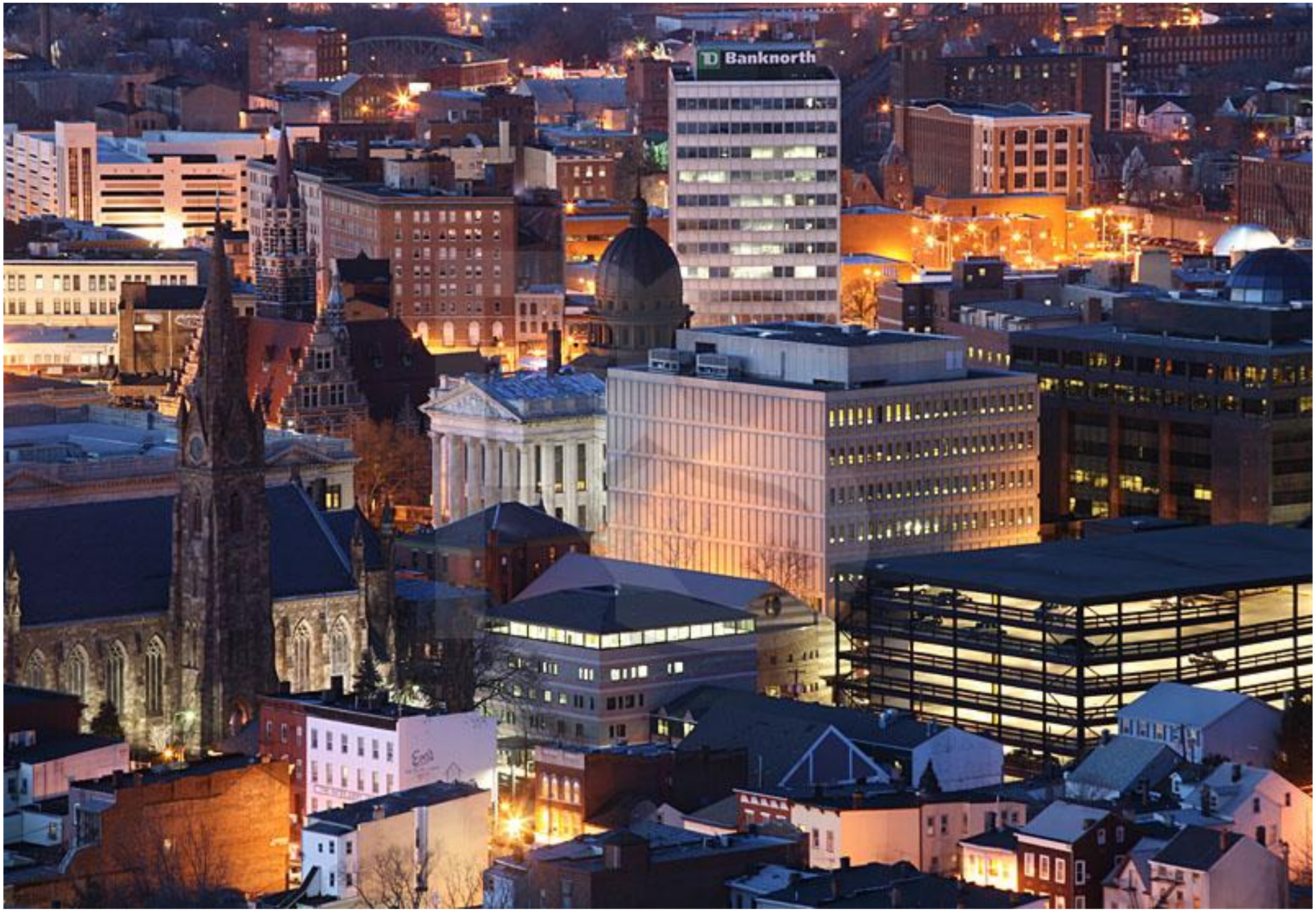
Bergen-Passaic TGA
Chief Elected Official – Mayor Jeffery Jones
Administered by the City of Paterson/Department of Human Resources
Funded by Health Resources and Services Administration Bureau/
Bureau of Health Resources

- Background
- Guiding Principles
- Needs Assessment
- Cultural and Linguistic Competence Policy Assessment
- Recommendations

- Demographics of the TGA
- The Part A Program
- Linguistic Standards
- Existing Competencies

The Bergen-Passaic TGA is a tale of two counties and a city.


The Bergen-Passaic TGA
Wayne
Pike
Orange
Putnam
Westchest
Sussex
Passaic County
Rockland
Bergen County
Monroe
Morris
Essex
Bergen
Newark
New York
Elizabeth
Union
Queens
Kings
Northampton
Allentown
Somerset
Hunterdon
Middlesex
Bucks
Mercer
NEW JERSEY
Montgomery
Monmouth
Philadelphia
Ocean
Delaware
Burlington



Paterson New Jersey

- Passaic County differs significantly from Bergen County, and Paterson differs significantly from both counties on most measures.

- On almost every indicator of social and economic status, as it impacts the status of the epidemic and/or the ability to respond to the needs of PLWHA.

- If the TGA has a problem, then Passaic County's problem is worse and Paterson's is the worst.

- The State of New Jersey ranks seventh in the nation in the percentage of Hispanic population (18%), and the Bergen-Passaic TGA is third highest in the state.

- The Bergen-Passaic TGA contains a significant and growing representation of minority populations.
  - Hispanics - 24%;
  - Blacks, non-Hispanic - 8%;
  - Asians - 11%.

- The 2010 Census results shows these minorities not only continue to increase but are doing so faster than projected during the previous decade.

- The TGA is a rich mosaic of other ethnic cultures as well.

- Recent census estimates indicate 28% as foreign born with more than fifty languages spoken in the home.

Bergen

- Foreign-Born-28%
  - Rank among 21 Counties -2 highest
- Language-36%
  - Rank-5
- Speak English “less than well”-38%
  - Rank-12
- Immigrant mothers-40%
  - Rank-5

Passaic

- Foreign-Born-28%
  - Rank among 21 Counties –2 highest
- Language-44%
  - Rank-2
- Speak English “less than well”-50%
  - Rank-2
- Immigrant mothers-47%
  - Rank -3

- Administered by the City of Paterson Department of Human Resources Ryan White Grants Division
- In existence since 1994
- 15 Ryan White Part A, four Minority AIDS Initiative (MAI), and six HOPWA sub-grantees
- Services located across both counties and concentrated in the epicenters

- **Culturally diverse Grantee personnel**
- **Bi-lingual capacity contractually required of all sub-grantees**
- **History of cultural competency training**
- **General perception of cultural sensitivity**

1. **Why do we need to do more?**

AND

2. **How do we raise the bar on cultural competency?**

- **Renewed emphasis on quality spreading beyond patient care**

- **General recognition that the cultural communities hold the key to prevention, early detection and linkage to care**

- **GOAL: TO STRENGTHEN CULTURAL COMPETENCIES IN SERVICE DELIVERY**

- **OBJECTIVE: Implement a continuous cultural competency process at all levels, utilizing the New Jersey Cultural and Linguistically Appropriate Service Standards (NJCLASS) as the basis. These standards were initiated in 2001 and training commenced in 2003.**

THE CULTURAL COMPETENCY TASK FORCE

BASICS AND GUIDING PRINCIPLES

- Guided by the Planning & Development Committee, envisioned in 2009 and convened in 2010
- Twenty-one members and guests from the TGA
  - Ryan White and non-Ryan White organizations
  - Colleges
  - Consumers
- Representing 17 of 18 identified cultural communities

The Bergen-Passaic Transitional Grant Area Ryan White Part A Program envisions a service delivery system that

- **Acknowledges any and all cultures with a universally respectful approach**
- **Understands and tolerates differing attitudes about health care**
- **Provides a sharing environment between provider and client**

A. Language translation services

B. A staff knowledgeable and understanding of the client's culture, religion and background

C. Assessed and evaluated culturally effective approaches by trained staff and implemented in culturally sensitive manner

D. Ability to make proper referrals and access appropriate resources

E. Respect, encouragement and motivation relative to cultural identity

F. Policy that allows a flexible approach to do the job

G. Knowledge, awareness and understanding about the communities served

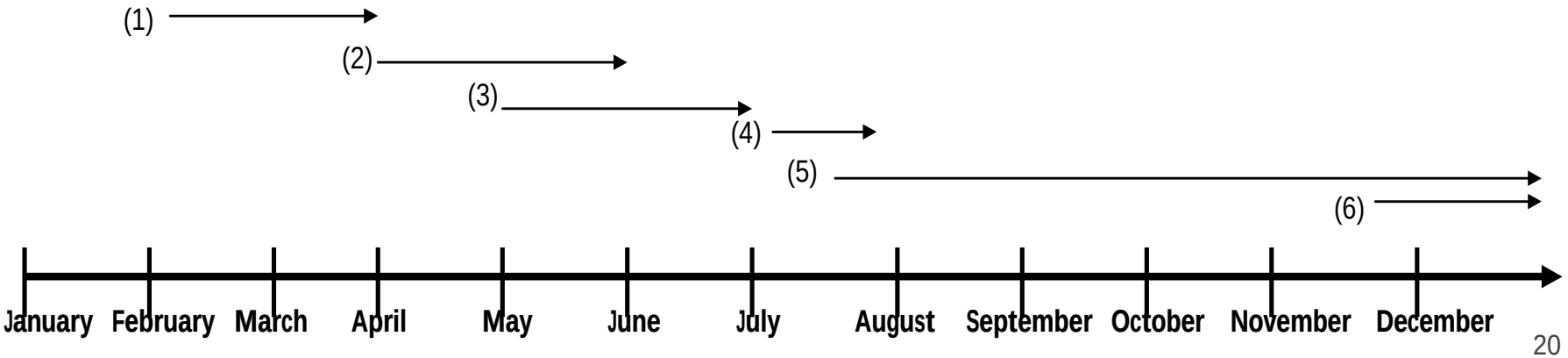
GOAL: TO STRENGTHEN CULTURAL COMPETENCIES IN SERVICE DELIVERY.

OBJECTIVE: Implement a continuous cultural competency process at all levels, utilizing the New Jersey Culturally and Linguistically Appropriate Services (NJCLAS) standards as a basis, by 2012.

Phase I: Where Are We Now?

(1) Develop working definition of cultural competency - Completed
(2) Formulate a Vision Statement - Completed
(3) Review of existing standards - Completed
(4) Identify key success factors leading to cultural competency - Completed
(5) Provider Self Assessment – Completed
(6) Year-end evaluation - Completed

TIMELINE
2010

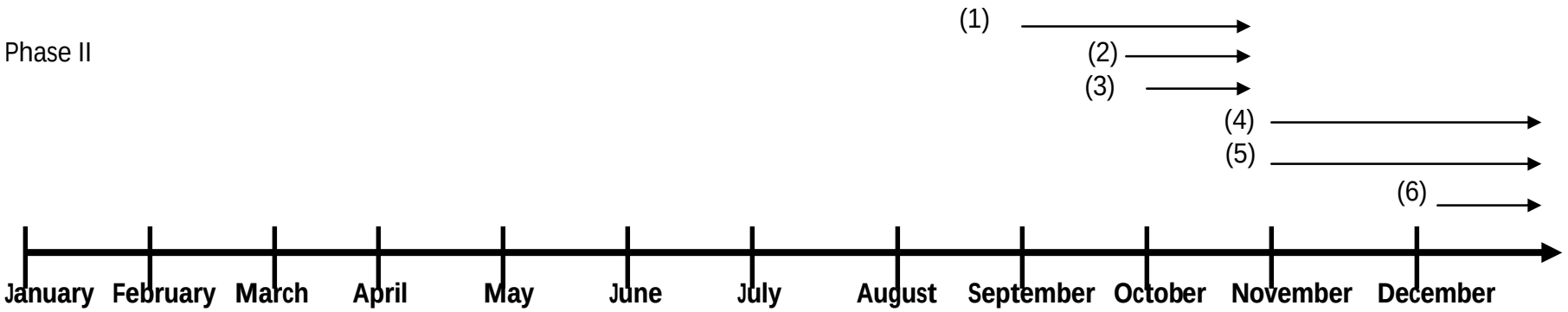


Phase II: Where Do We Want to Go?

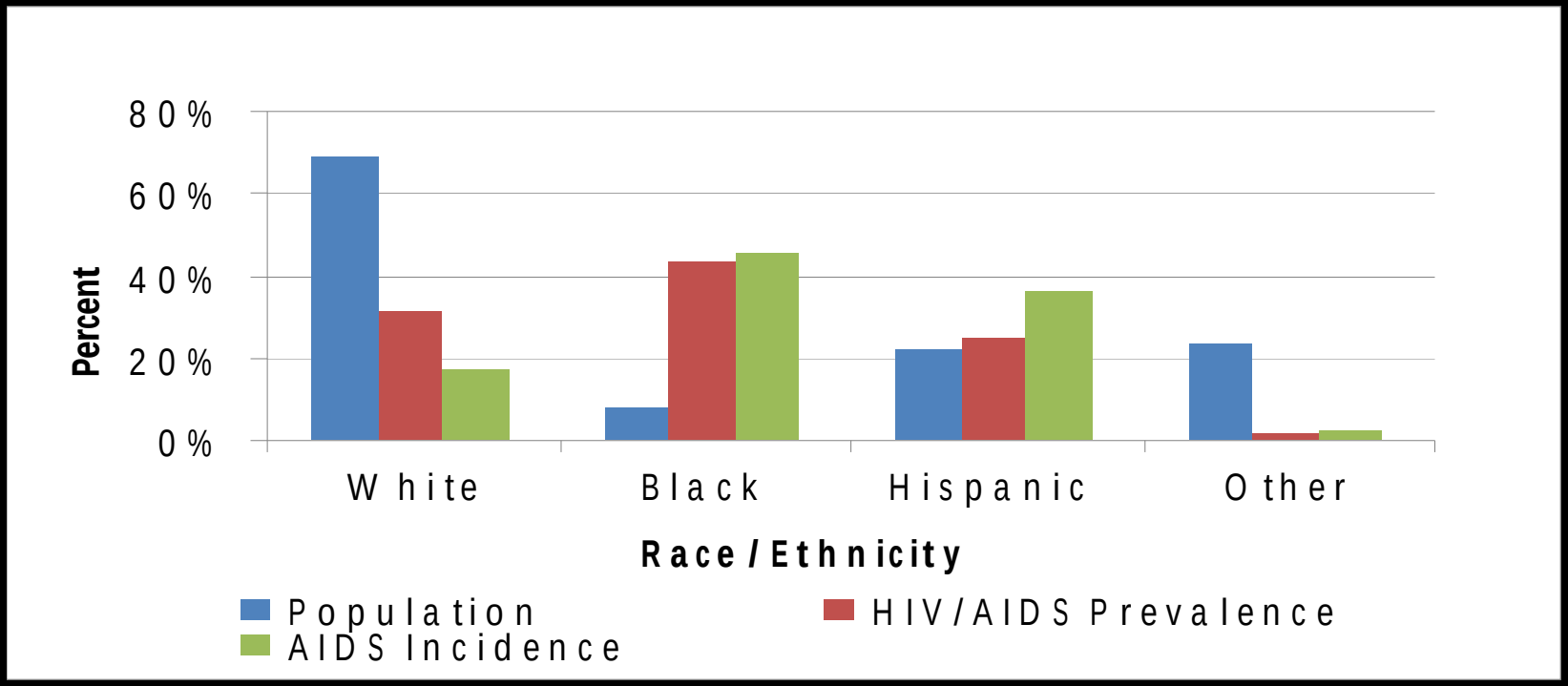
1. Identify Goals – Long Term and Annual
2. Develop a CC Plan for the TGA (Includes Action Plan and Roadmap)
3. Develop Working Tools and Strategies to Achieve the Goals and Objectives
4. Develop Cultural Competency Standards for the TGA
5. Develop Agency-specific QM Plans, Organizational Plans, etc.
6. Year-End Evaluation

TIMELINE
2011

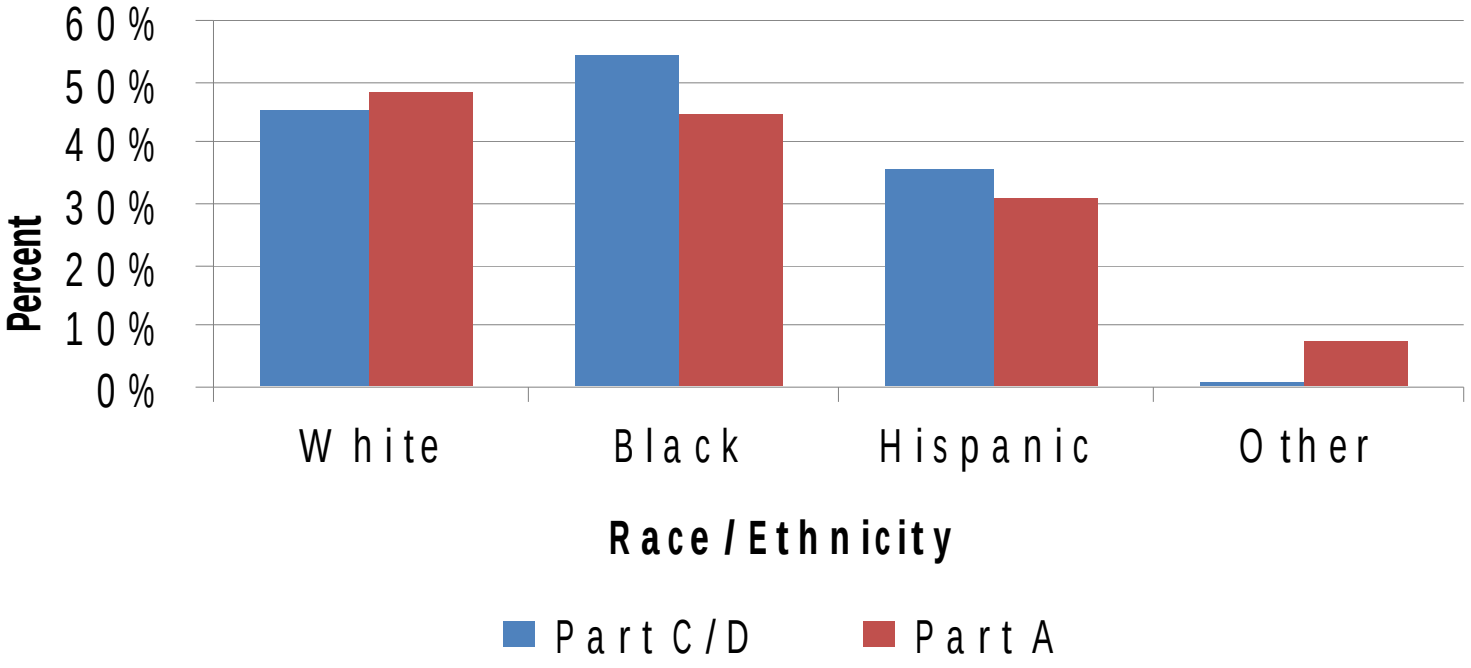
Phase II



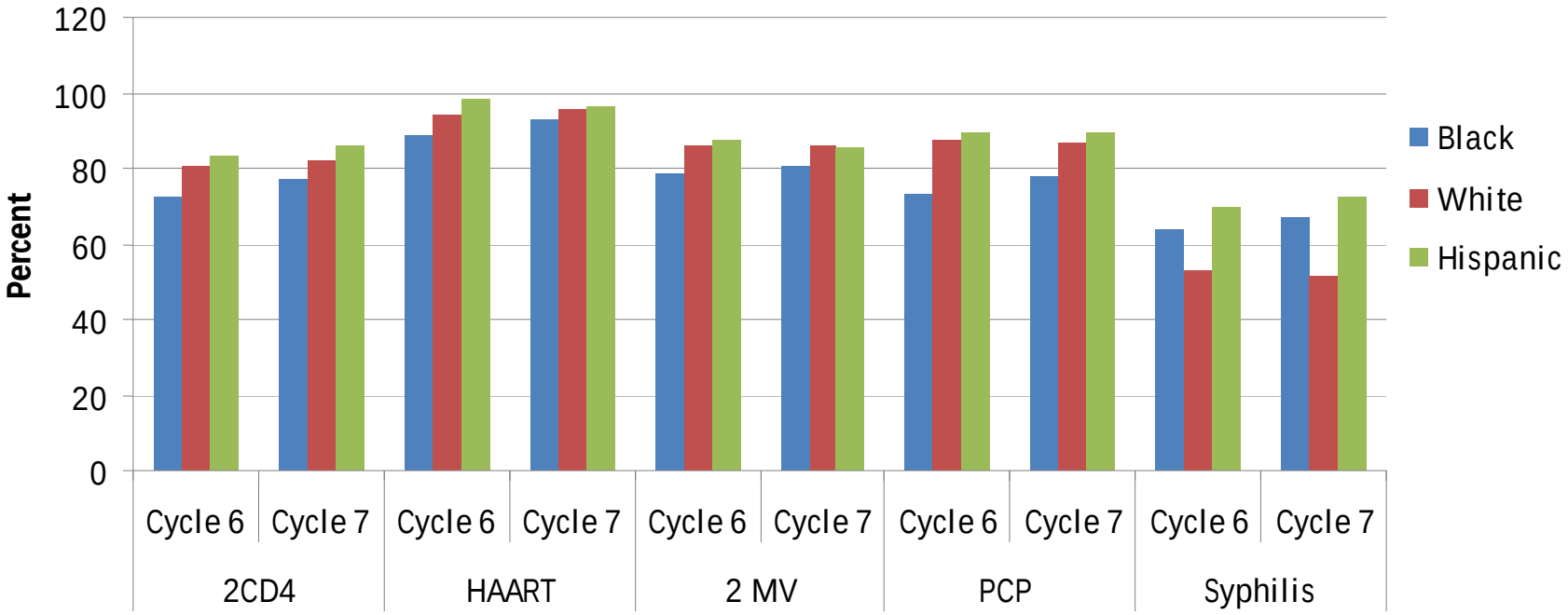
NEEDS ASSESSMENT



Disproportionate Impact
Population vs HIV Epidemic 2008/2009

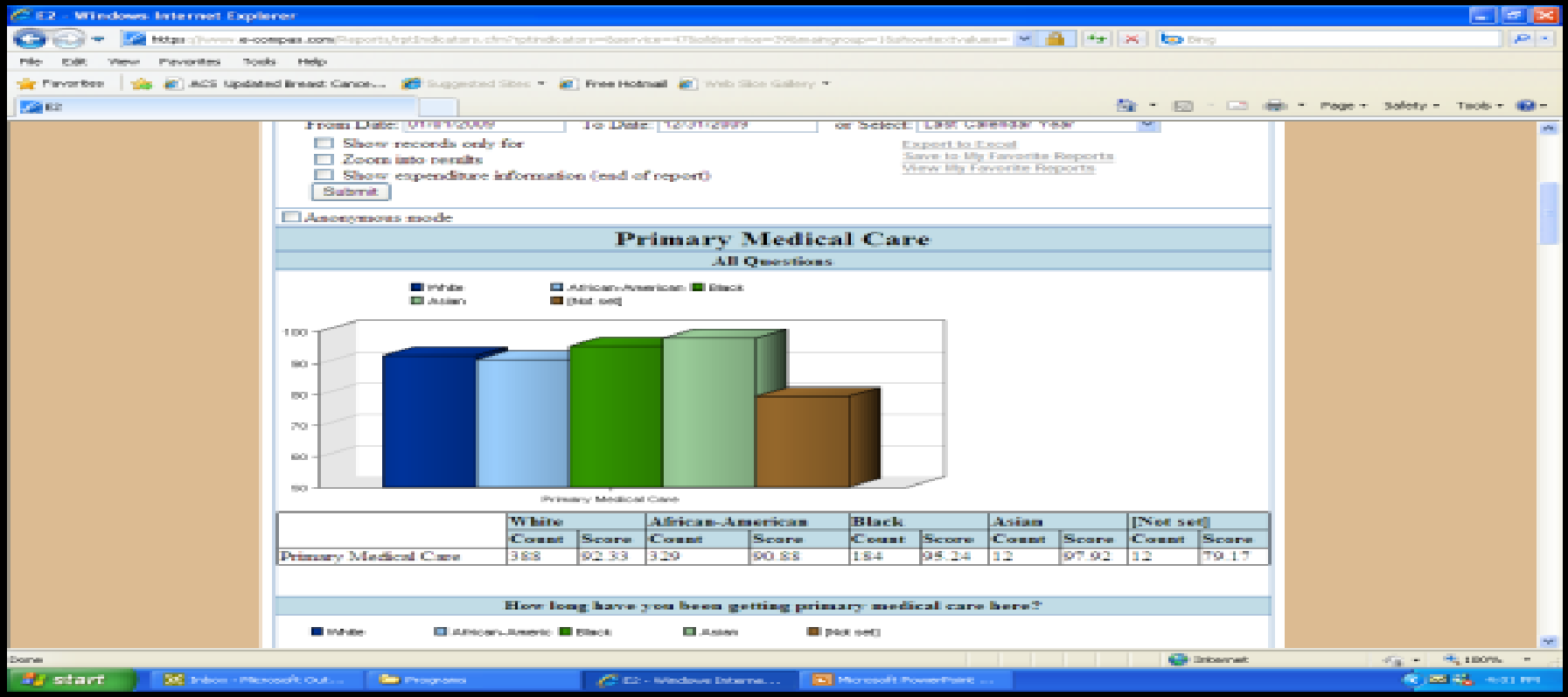


HIV Medical Care
Race/Ethnicity 2009



Definitions:
2CD4 = % of patients who had 2 or more CD4 T-cells in the year
HAART = % of patients with AIDS who are prescribed HAART
2MV = % of patients with HIV who had 2 or more medical visits in HIV setting
PCP = % of patients with HIV and CD4 T- cell count < 200 prescribed PCP prophylaxis
Syphilis = % of patients with HIV 18 years of age and older with a syphilis screen

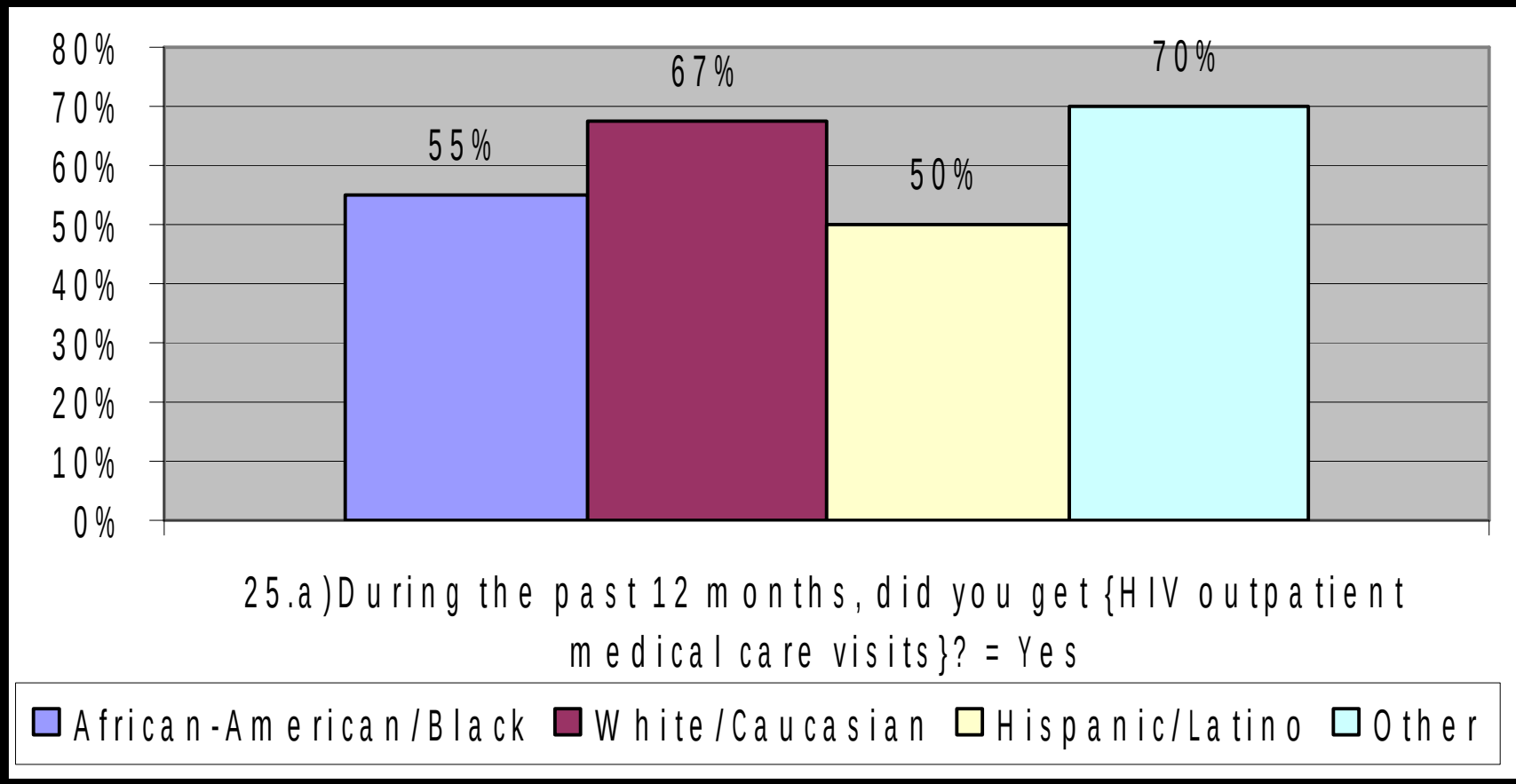
Quality: NJ CPC Cycle 6 Data by Race & Ethnicity



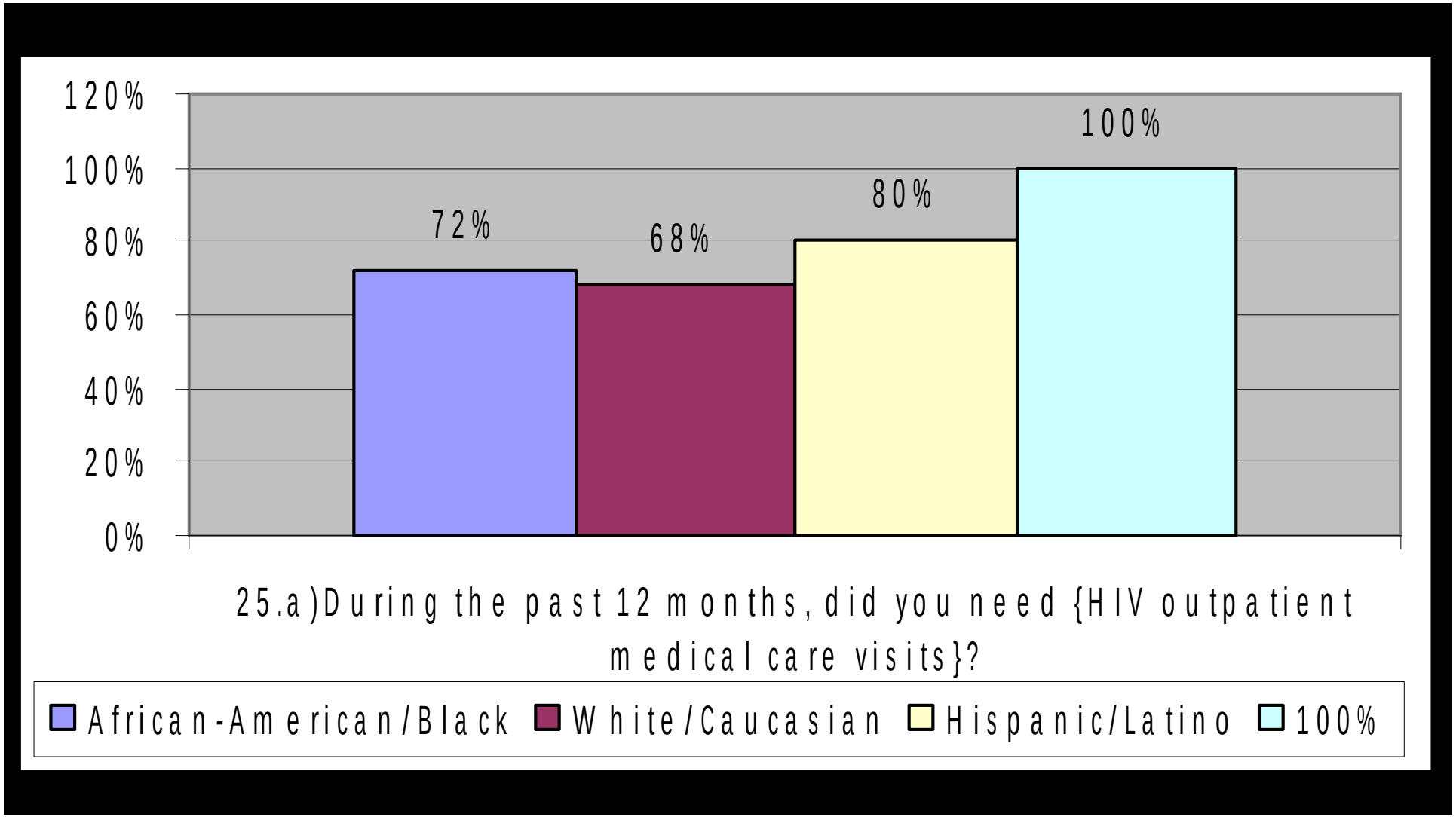
	White		African-American		Black		Asian		[Not set]	
	Count	Score	Count	Score	Count	Score	Count	Score	Count	Score
Primary Medical Care	388	92.33	329	90.88	184	95.24	12	97.92	12	79.17

Client Satisfaction by Race

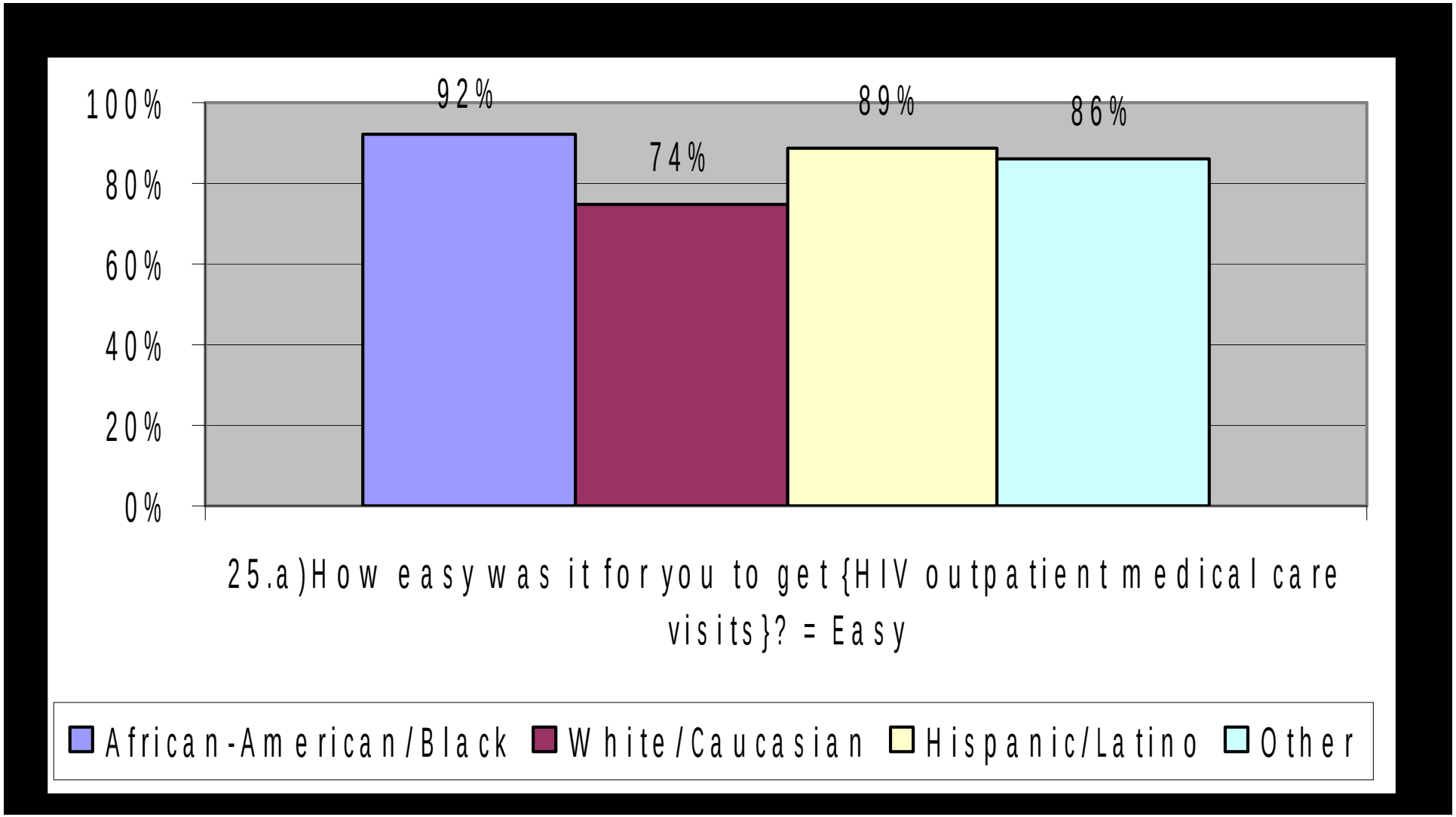
Primary Medical Care



Bergen-Passaic Needs Assessment
In-Care Respondents by Race/Ethnicity



Bergen-Passaic Needs Assessment
Out-of-Care Respondents by Race/Ethnicity



Bergen-Passaic Needs Assessment

Access to Medical Care by Race/Ethnicity

- The HIV client population is generally reflective of race/ethnicity within the HIV epidemic
- Differences among races, ethnicities and sexual orientations are small
- Black, African-Americans tend to demonstrate less favorable quality indicators
- Client satisfaction scores tend to be less favorable among GLBT clients, especially for mental health therapy
- Hispanics tend to be more frequently out-of-care and express greater need for outpatient medical care
- GLBT clients identify personal or cultural barriers more often than other populations

Cultural and Linguistic Competence Policy Assessment

- Intended to measure the level of cultural competencies by RW Part A sub-grantees
- Standardized survey developed by the National Center for Cultural Competence, Georgetown University Center for Child and Human Development
- Administered online to all RW Part A sub-grantees in 2011
- Provided a reference for task force recommendations

- Respondent Demographics
- General Knowledge Questions
  1. Knowledge of Diverse Communities
  2. Organizational Philosophy
  3. Personal Involvement in Diverse Communities
  4. Resources and Linkages
  5. Human Resources
  6. Service Practice
  7. Engagement in Diverse Communities
- Supporting Policies

- 15 out of 17 Ryan White Part A Providers
- 42 Individual Respondents
- 1 Board Member
- 12 Administrators
- 16 Direct Service Providers
- 13 Other (clerical, lab, reception, etc.)

- **In general, providers have acknowledged and are working toward proficiencies in cultural competencies**
- **Some knowledge gaps are apparent**

- Knowledge of diverse communities, especially with African-American and Latino communities
- Language proficiencies, especially Spanish
- Regulation compliance and protocols
- Commitment

- Staff racial and ethnic representation disproportionate to PLWH
- External connection with diverse communities
- Effectiveness evaluation
- Use of medical and sign interpreters

- Internal policies
- Organizational goals
- Staff incentives
- Assessment of health literacy

The Cultural Competency Task Force embraces standards for cultural competency, as established in the New Jersey Cultural and Linguistically Appropriate Service Standards for HIV/AIDS Service Providers, New Jersey Department of Health and Senior Services Division of HIV/AIDS Services, June 2003. (NJCLASS)

Culture includes but is not limited to race, ethnicity, spoke and written language, sexual orientation, gender identify, substance abuse, physical challenge, homelessness, mental illness, religion, etc.

1. **HIV/AIDS service providers should ensure that the services that consumers receive from all staff are client centered, understandable, respectful, outcome oriented and compatible with clients' cultural beliefs, practices and preferred language.**

2. **HIV/AIDS service providers should implement strategies to recruit, retain, and promote diverse staff and leadership at all levels of the organization that are representative of the demographic characteristics of the service area.**

3. **HIV/AIDS service providers should ensure that staff at all levels and across all disciplines receives ongoing education and training in culturally and linguistically appropriate service delivery.**

4. **HIV/AIDS service providers should render all services in the preferred language of their clients at every point of service delivery, utilizing the services of bilingual staff and interpreters at no cost to the client.**

5. HIV /AIDS service providers should make available easily understood written materials and signage in the clients' preferred language.

6. HIV/AIDS service providers should ensure that socio-demographic and culturally related data are collected, tracked, and used in strategic planning and program implementation. Data should include: race, ethnicity, spoken and written language, sexual orientation, gender identity, and substance abuse history.

7. HIV/AIDS service providers should conduct an initial and ongoing organizational self-assessment of culturally competent and linguistically appropriate related activities.

8. HIV/AIDS service providers should maintain the most current demographic and epidemiological profile and needs-assessment to plan for and provide services that respond to the cultural and linguistic characteristics of their clients.

9. HIV/AIDS service providers should develop and implement a written strategic plan that outlines clear goals, policies, operational plans, management and accountability mechanisms to provide culturally and linguistically appropriate services.

10. HIV/AIDS service providers should ensure that conflict and grievance/complaint processes are culturally and linguistically sensitive and capable of identifying, preventing and addressing cultural differences that might result in conflicts.

11. HIV/AIDS service providers should collaborate with the communities they serve and utilize a variety of mechanisms to facilitate involvement in the design and implementation of culturally competent and linguistically appropriate activities.

12. HIV/AIDS service providers should regularly disseminate to the public information about the organization's progress in implementing cultural competency and linguistically appropriate standards.

RECOMMENDATIONS

I. To create a culture of competency within the organizations

II. To achieve competency at all levels of the organizations

III. To establish a deeper involvement with communities served

IV. To achieve a deeper respect for cultural differences

1. Create and incorporate within the Bergen-Passaic TGA standards of care a universal policy statement of cultural competency
2. Incorporate the universal policy statement of cultural competency into contractual requirements for Part A providers

3. **Expand agency policies by broadening the practice of cultural competency to include:**
   - Knowledge of Diverse Communities,
   - Organizational Philosophy,
   - Personal Involvement in Diverse Communities,
   - Resources and Linkages,
   - Human Resources,
   - Clinical Practice,
   - Engagement of Diverse Communities
4. **Develop and adopt a cultural competency policy for the Planning Council**

5. Provide linguistically competent services for the major ethnic communities served by the providers in the Bergen-Passaic TGA. Major communities will be defined by the provider.
6. Empower consumers to express their values, attitudes and belief systems around health practices
7. Empower consumers to understand their health choices through enhanced health literacy

8. **Provide training to supervisory and staff employees on each of the following:**
   - **Knowledge of Diverse Communities,**
   - **Organizational Philosophy,**
   - **Personal Involvement in Diverse Communities,**
   - **Resources and Linkages,**
   - **Human Resources,**
   - **Clinical Practice,**
   - **Engagement of Diverse Communities**

9. **Provide agency-specific training to supervisory and staff employees on the following:**
   - **Addressing gaps revealed in the Cultural and Linguistic Competence Policy Assessment;**
   - **Improving communication throughout the organization;**
   - **Working through cultural differences within the communities served;**
   - **Measuring effectiveness through Quality Improvement.**

10. **Provide training employing the following approaches:**
    - Beyond the basics
    - Interactive and concrete
    - Methods to be incorporated into the daily operations of the organization
    - Experiential at some level (not solely lecture oriented)
    - Results oriented – measurable
11. **Invite community stakeholders to participate in training activities, both at the TGA and agency levels**

12. **Obtain ongoing input from clients on their specific cultural needs.**

13. **Work with consumers to develop Insightful client satisfaction surveys.**

14. **Reinforce and encourage client/provider communication to ensure the provision of culturally competent services.**

15. Educate the community to help achieve the goals of the TGA through:

- Direct involvement in community activities to foster deeper understanding of the diverse cultures
- Social marketing/community education to reduce stigma
- Increase readiness for HIV testing
- Educating community leaders on stigma, cultural respectfulness, and the need for an improved quality of life

16. **Build constructive relationships with key diverse communities of each agency, to be identified by the agency itself. Extend the dialogue with cultural brokers through interaction, involvement and support of local initiatives.**

17. Establish a Cultural Competency Quality Improvement Program (Comprehensive Plan Objective II.3) to include:

- Quality Indicators
- Benchmarks
- Analysis
- Improvement Methods (Plan-Do-Study-Act, Peer Learning, etc.)
- Ongoing Review

18. Allow the funded agencies to select improvement methods most amenable to their needs and abilities, following a general orientation to the various methods available to them.

19. Incorporate cultural competency quality improvement requirements into the Part A contracting process. Require providers to identify a minimum of one cultural competency QI indicator per year and establish an improvement plan that includes outcome measurement.

All service providers of the Bergen-Passaic Transitional Grant Area Ryan White Part A Program will adopt a policy and procedures that explicitly:

- **Acknowledge any and all cultures with a universally respectful approach;**
- **Understand and tolerate differing attitudes about health care;**
- **Provide a sharing environment between provider and client;**
- **Practice effective communication skills and responds to the client's level of understanding, perception and perspective;**
- **Support and ensures ongoing cultural competency staff education;**
- **Establish systemic policy to provide reasonable accommodation, adaptability and necessary tools for cultural competency.**

IMPLEMENTATION

- **Level 1** — Immediate – implemented within six months
- **Level 2** — Short term – implemented in six to twelve months
- **Level 3** — Long term – implemented in twelve to twenty-four months

	Recommendation		
Area	**Immediate**	**Short Term**	**Long Term**
Policy	1, 2, 4		3
Linguistic Competency and Health Literacy	6,7		5
Training	8	9	10, 11
Consumer Involvement	12, 14		13
Community Involvement		16	15
Quality and Measurement	19		17, 18

WORKSHOP

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