

## **CMS/Ped-I-Care Cultural Competency Plan**

The following document helps to outline cultural competency by definition and behaviors to aid the CMS/Ped-I-Care staff and providers in serving a diverse population of families. It was created from the cultural competency study conducted in Gainesville in 2006-07 by Carolyn Tucker, Ph.D., Professor of Psychology at the University of Florida and Sharon Surrency, RN, Regional Nursing Director for CMS North Central Region.

I. Cultural Competency/Sensitivity: mandates that organizations, programs and individuals must have the ability to:

- A. Value diversity & similarities among all people
- B. Understand & effectively respond to cultural differences
- C. Engage in cultural self-assessment at the individual & organizational levels
- D. Make adaptations to the delivery of services & enable supports
- E. Institutionalize cultural knowledge

MCHB definition (1999)

II. Impetus for Focusing on Patient-Centered Culturally-Sensitive Health Care (PC-CSHC)

- A. The Institute of Medicine included patient-centered care among its six domains for improving quality of care (Institute of Medicine, 2001)
- B. Culturally insensitive health care systems have been identified as a major contributor to the health disparities problem (American College of Physicians, 2004)
- C. There are national calls for development of patient-centered culturally sensitive health care assessments (Agency for Health Care Quality and Research, 2005)
- D. The views of children/regarding what is culturally sensitive health care have not been assessed (AHRQ, 2005)

III. Characteristics of PC-CSHC

A. It is “cultural competence plus”

1. It views the patient-provider relationship as a partnership
2. It is patient empowerment-oriented in that:
  - a. patients as well as providers are viewed as “experts”
  - b. patients as well as providers/staff are trained
  - c. patients routinely provide cultural sensitivity feedback.
3. It is demonstrated by provider/staff behaviors and clinic environments that help patients feel comfortable with, respected by, and trusting of their health care providers.

Tucker et al. (2002); Tucker et al. (in press)

**Findings COMMON to African American and White American Parents/Caregivers  
NCC Comfort, Respect, and Trust Behaviors**

<b>Promotes</b>	<b>Inhibits</b>
Caring/Concerned	Dishonest
Helpful/Informative	Disrespectful
Courteous/Respectful	Non-contact
Familiar	Rushing
Friendly/Nice	Uncaring
Honest	Unhelpful
Competent	Impersonal
Knowledgeable of the patient	Violates your privacy
Aware of the patient’s history	
Protection of privacy	

IV. Summary of Research Findings of Activities that Promote Cultural Sensitivity

- A. African American and White American adolescents and parents were much more similar across gender and age group than they were different.

- B. Whereas responses specific to African American adolescents emphasized pleasant interpersonal behaviors, the responses specific to the White American adolescents emphasized technical job performance behaviors.
- C. In general, the responses of African American and White American parents/caregivers equally emphasize both pleasant interpersonal behaviors and technical job performance behaviors.
- D. The following are three behaviors that the adolescents identified that the African American and the White American parents/caregivers did not identify:
1. speaks directly to me (White Americans)
  2. engages in whispering (African Americans)
  3. pats me on my back (African Americans)

#### V. Ways to Convey the Identified Subjective Behaviors and Characteristics

A. Is friendly, nice, helpful, gentle, and treats one as a person

- Smile (during office visits)
- Enthusiastically say “hello, great to see (talk with) you.”
- Generally use a soft calm voice
- Give positive feedback frequently
- Share positive feelings associated with the patient or parent/caregiver
- Asks what you can do to be more helpful
- Ask about the non-health /medical aspect of the patient’s life (e.g., school)
- Remember to ask about significant life events shared with you at an earlier time
- Send a card/email to acknowledge significant events (e.g., a death, birth)

B. Is listening

- Ask open-ended questions and make open-ended requests (i.e., that can not be answered “yes” or “no”)
- Periodically ask the patient and the patient/parent caregiver if they felt listened to, and if not, ask what would assure them that they were being listened to
- Say “yes”, and “I understand” to convey active listening
- Use good eye contact and ask for this contact
- Show compassion; say “That must have been difficult for you.”
- Talk much less than the adolescent and the parent

- At the beginning of a meeting, say how much time you have to talk and that you intend to listen carefully to make the most out of this time

#### C. Is respectful

- Ask the adolescent and parent/caregiver how she/he would like to be addressed
- Ask for the opinion of the adolescent and her/his parent/caregiver
- Say, “I truly respect your opinion; your opinion matters to me; and /or “thanks so much for sharing your opinion”
- Ask for good times to make CMS calls to your patient’s home and use those times

### VI. Common Parent/Caregiver Identified Behaviors and Characteristics

#### A. Is familiar with the patient

- Have notes on the patient’s medical condition available when calling that patient and ask for any new health related information
- Mail the adolescent and her/his parent/caregiver, a brief NCC autobiography to promote mutual familiarity

#### B. Is knowledgeable, helpful, and honest

- Solicit questions from the patient and parent caregiver but with the understanding that you will provide answers when time permits.
- Express your commitment to the work that you do
- Say what you do not know and then find needed answers
- Obtain written permission to email patients, if email use is an option