Cultural competence and diversity responsiveness: how to make a difference in healthcare?

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7 How should health service organizations respond to diversity? An analytic framework based on a comparison of six approaches
Abstract

Context

Health care organizations need to be responsive to the needs of increasingly diverse patient populations. We developed an analytic framework based on a comparison of six approaches for organizational responsiveness to diversity. The central questions addressed in this paper are: what are the essential elements of health services that are responsive to the needs of groups differing from the majority population? How much consensus is there between various approaches?

Methods

We selected six approaches from the US, Australia and Europe and used qualitative analysis to categorize the content of each approach into ‘domains’ (conceptually distinct topic areas) and, within each domain, into ‘dimensions’ (operationalizations). The resulting classification framework was used for comparative analysis of the content of the six approaches.

Findings

We identified seven domains that were represented in most or all approaches: ‘organizational commitment’, ‘empirical evidence on inequalities and needs’, ‘a competent and diverse workforce’, ‘ensuring access for all users’, ‘ensuring responsiveness in care provision’, ‘fostering patient and community participation’ and ‘actively promoting responsiveness’. Variations in the conceptualization of ‘responsive care’ reflected different assumptions about the type of diversity that should be responded to. For example, approaches that focus on ethnic diversity refer mostly to cultural and language differences; approaches that broaden their target populations to (e.g.) ‘vulnerable’ groups adopt a more multidimensional approach, also paying attention to such factors as socio-economic status and gender.

Conclusions

According to current conceptualizations, organizational responsiveness to diversity in health care means ensuring access and providing appropriate care. The analytic framework also defines several preconditions, such as demonstrating organizational commitment, developing a competent and diverse workforce, and fostering patient and community participation. Despite differences in the way different approaches are labeled, this comparative study reveals a broad consensus among different approaches concerning the way in which health service organizations should respond to diversity.
**Introduction**

Health service users belonging to groups that differ in certain respects from the majority population, such as migrants, ethnic minorities and other groups sometimes referred to as ‘vulnerable’, often receive poorer care than majority users. Variously described as ‘health care disparities’, ‘inequalities’ or ‘inequities’, these problems in healthcare have been well documented in the United States (1,2) and are increasingly being recognized in other countries (3-5).

The existence of these problems implies that health services may need to be adapted in order to increase their accessibility and quality for service users who differ from assumed norms. Such responsiveness to diversity has for several decades been referred to as ‘culturally competent care’. This concept was first developed in the USA in relation to ethnic minorities, but in recent years there has been a growing realization that many other groups are also not optimally served by standard services. In the USA, the response has been to retain the label of ‘cultural competence’ but to broaden the definition of ‘culture’ to reflect such attributes as migrant status, socioeconomic position, geographical location, gender, religion, age, sexual orientation or disability (6,7). In other countries, however, widening the range of target groups has been seen as a shift away from the focus on ‘culture’. Rather than speaking of ‘cultural competence’, advocates of responsiveness to diversity have used terms such as ‘promoting equitable health care’, or ‘protecting vulnerable groups’ (8). Despite the differences in terminology, we will argue in this paper that these disagreements are to a large extent a question of semantics.

Whichever approach is adopted, promoting responsiveness to diversity requires interventions at several levels of the health system. At the level of individual caregivers, three elements of responsive care have been emphasized: knowledge, skills and attitudes (9,10). At the level of health service organizations, promoting responsiveness involves putting into place certain key elements in service policies and management (8). Some approaches address the level of entire health systems, in which case interventions at national (or state) as well as organizational or individual levels are discussed.

In this article we will examine only recommendations that have been put forward at the organizational level, while recognizing that responsiveness to diversity also has important implications for the other two levels. Approaches differ according to the target group for which they were principally intended and the assumptions that underlie them. In the USA, ‘cultural competence’ has been promoted at the organizational level through the CLAS standards (Standards for Culturally and Linguistically Appropriate Services) (11). In Europe, recommendations have been published referring to goals such
as ‘migrant friendliness’ (12), ‘intercultural opening’ (13), ‘transcultural competence’ (14) or ‘difference sensitivity’ (15).

So far no systematic analyses have been carried out to establish whether there are important differences in content between these approaches. To what extent does consensus exist about the measures that organizations should take in order to adapt health services to the needs of diverse patient populations? Without such consensus, no general principles can be laid down for improving responsiveness, nor can general criteria for measuring progress towards this goal be defined.

In this paper we have developed an over-arching analytic framework within which different approaches can be described, compared and contrasted. The paper examines six approaches and addresses the following questions:

1. On which aspects of health service provision (‘domains’) do the different approaches focus?
2. How much agreement is there concerning the domains that are important?
3. How much agreement is there in the way the tasks within each domain are operationalized in ‘dimensions’?

The answers to these questions will shed light on our central question: what are the essential elements in providing care that is responsive to the needs of groups differing in certain important respects from the majority population, and how much consensus is there between various approaches?

**Method**

**Choice of approaches**

In recent years many guidelines or recommendations for increasing organizational responsiveness to diversity have been published by both public and private bodies. To compare all these approaches would have been an impossibly large task, so we selected six approaches using the following criteria:

- the approach was developed for widespread (more than local) use;
- it was developed by an organization with some authority; and
- it was publicly available.

In addition, we wanted to compare approaches from US, Australian and European sources.

The following approaches were selected: 1) CLAS Standards - National Standards for Culturally and Linguistically Appropriate Services in Health Care (further referred to as: CLAS) developed by the Office of Minority Health, part of the U.S. Department of Health and Human Services (11); 2) Advancing Effective Communication, Cultural Competence,
and Patient- and Family Centered Care: A Roadmap for Hospitals (further referred to as JCR), developed by the Joint Commission (16); 3) Cultural Responsiveness Framework. Guidelines for Victorian health services (further referred to as CRF) developed by the Victorian Government, Department of Health (17); 4) Recommendation of the committee of ministers to member states on mobility, migration and access to health care (further referred to as COER) of the Council of Europe (18,19); 5) The Equality Delivery System (further referred to as EDS) for the NHS (20); 6) Standards for Equity in Health Care for Migrants and other Vulnerable Groups (further referred to as EQS) developed by the Task Force on Migrant-Friendly and Culturally Competent (21). Box 7.1 briefly describes each approach and clarifies our reasons for including the approach in our study.

In May 2013 the Enhanced CLAS Standards were published, entitled “National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice” (7). A comparison of the new Standards with the original version showed that the underlying ideas were virtually identical to those which informed the first edition. Indeed, the accompanying texts made clear that the aim of the revision was mainly to increase the effectiveness of the Standards, by explaining them more clearly, ensuring that they reflected recent developments, and aligning them with other initiatives such as the Affordable Care Act and the work of the Joint Commission. Some differences of emphasis are described in Box 7.1. The version of CLAS used in this paper is the original one: we do not feel the changes made in the enhanced version are extensive enough to warrant a separate analysis.

**Box 7.1 Description of the six approaches on responsive health care that were included.**

**CLAS Standards - National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)** (11). These standards were developed by the Office of Minority Health, part of the U.S. Department of Health and Human Services. Some of the standards have the status of mandates, meaning that they are Federal requirements for all health care organizations that receive Federal funds; others are purely recommendations. We included the CLAS standards because they are probably the most comprehensive and influential approach in use. In May 2013 the Enhanced CLAS Standards were published (7). Although largely similar, there are some differences of emphasis between the original and the Enhanced CLAS Standard appeared of which we would like to mention:

A broader definition of “culture” was adopted. In the original version, culture was defined as being “associated with racial, ethnic or linguistic groups”. In the new definition, this was expanded to include “religious, spiritual, biological, geographical, or sociological characteristics”, thus extending the relevance of CLAS standards beyond racial and ethnic minorities to a wide range of types of diversity. Although many new groups are now
intended to fall under the scope of CLAS, the only feature of these groups which is taken account of is still their culture (defined as an “integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions”). Other features such as social position, material limitations or legal situation are not mentioned.

In the vision on responsive care some slight changes of emphasis could be found, such as a shift from regarding diversity as a ‘group’ characteristic to ‘appreciating the diversity of individuals’. The enhanced CLAS also places more emphasis on the importance of ‘patient- and family centred care’, thus bringing it more into line with the JC Roadmap

**Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care: A Roadmap for Hospitals (JCR)** (16). This ‘Roadmap’ has been developed by the Joint Commission (JC), an independent, not-for-profit organization which accredits and certifies health care organizations in the United States. The Roadmap was developed in addition to existing JC requirements “to inspire hospitals to integrate concepts from the fields of communication, cultural competence, and patient- and family-centered care into their organizations.” We included the JC Roadmap because of the global influence of JC and the Joint Commission International (JCI) accreditation program on health care organizations through their accreditation programs (applied in over 50 countries).

Although attention to healthcare for ethnic minority patients within the JC started after a ‘gap’ analysis between the CLAS standards and the JC’s accreditation standards in 2003, the JC has developed its own framework of recommendations on issues of effective communication, cultural competence, and patient- and family-centered care. Therefore we consider the Roadmap to be related to the CLAS standards, but distinct from them. It is important to note that 1) existing JC requirements also include issues related to those issues discussed in the Roadmap, and 2) that the national Joint Commission Standards are different from the Standards of the Joint Commission International.

**Cultural Responsiveness Framework. Guidelines for Victorian health services (CRF)** by the Rural and Regional Health and Aged Care Services, Victorian Government, Department of Health (Australia) (17). The CRF was developed to replace the Health Service Cultural Diversity Plans (HSCDPs) which since 2006 have required all Victorian health services to develop and implement policies for ethnic diversity in care. The intention of the CRF is to consolidate multiple requirements for reporting on cultural diversity initiatives within health services. All Victorian health services are required to submit plans and achievements according to the standards and measures in the CRF to the Statewide Quality Branch. We included the CRF because it has been disseminated and made compulsory in a large health care system in Australia.

**Recommendation of the committee of ministers to member states on mobility, migration and access to health care (COER)** of the Council of Europe (18,19). The Council of Europe is an international organization set up “to achieve a greater unity between its members for the purpose of safeguarding and realizing the ideals and principles which are their common heritage and facilitating their economic and social progress” (32). We included the COER because it has been endorsed by the Health Ministers of the 47
member states of the Council of Europe. The document is aimed at ministerial level, therefore it includes recommendations that have consequences for the whole health system. To make comparisons possible we have only included the recommendations at organizational level in our analysis.

Equality Delivery System (EDS) for the NHS (20). EDS originates from the Equality and Diversity Council within the British National Health Service (NHS). It is designed to help NHS organizations to comply with the ‘Public Sector Equality Duty’ (PSED) of the Equality Act. This act “requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees” (33). EDS is made available to the NHS as an optional tool. It was included because it is a European instrument which has been disseminated in a large health care system.

Equity Standards (EQS) of the Task Force on Migrant-Friendly and Culturally Competent Healthcare (21,25). These Standards were developed by a group of mainly European experts set up within WHO’s Health Promoting Hospitals network. The Equity Standards are a self-assessment instrument to enable health care organizations to carry out an ‘equity evaluation’ against a set of standards. The instrument was piloted in 10 European countries, as well as in two non-European ones. The Equity Standards were included because of the broad international context in which they were developed.

Developing the Framework

The following stepwise approach was used to develop the analytic framework.

A. Encoding of content
1. The first approach analyzed was CLAS. The different CLAS standards were grouped into ‘domains’, i.e. conceptually distinct topic areas. Within each domain, different ‘dimensions’ were distinguished in order to show how the domain was operationalized.
2. A second approach was selected and its content was subsumed under the domains and dimensions identified in Step 1, new ones being created where necessary.
3. The four remaining approaches were treated in the same way.
4. The resulting system of domains and dimensions was critically reviewed by three of the authors in order to remove ambiguities and overlap.

B. Comparison of content
Categorizing the content of the approaches in this over-arching classification system enabled us to see at a glance whether certain domains were unique to, or absent from, particular approaches. Within each domain, it revealed the differences in the ways in which approaches operationalized the domain. In order to compare the six approaches, we listed the differences between them as well as their similarities.
Results

This section starts with background information on the six approaches. We then provide an overview and analysis of their content, classified according to the domains and dimensions of the framework that we developed. We then describe the similarities and differences between the six approaches.

Background information

Table 7.1 provides background information on the six approaches, listed with their acronyms (Table 7.1: see end of this chapter).

As their aim, the approaches refer to reducing or eliminating existing inequalities in health and quality of care between different populations (CLAS, COER, EQS), as well as improving outcomes for patients (JCR, CRF, EDS). Although all approaches aim at improving the quality of care, the motives underlying this goal are different. Some approaches (CLAS, COER, EQS) start from human rights principles, regarding inequalities between groups as injustices which should be eliminated. JCR considers equality as an indicator of performance, assuming that outcomes should be equal for all patients, while CRF and EDS combine both starting points. Two unique aims (not mentioned in other approaches) also emerge: CRF aims to enhance the cost-effectiveness of health service delivery, and EDS aims to create better working environments for staff.

In their vision on responsive care, three approaches directly invoke the concept of ‘cultural competence’. CLAS refers to the classic definition of cultural competence (Cross et al. 1989 (34)); at the same time, the term ‘culturally and linguistically appropriate services’ places separate and explicit emphasis on language issues. For JCR, cultural competence is one of three fundamental concepts on which the Roadmap elaborates (the other concepts being ‘effective communication’ and ‘patient and family centered care’). JCR operationalizes cultural competence in a similar way to CLAS. CRF introduces another concept: ‘culturally responsive care’. Although this term is chosen in preference to ‘cultural competence’, the vision implied is very similar to that of CLAS and JCR. A common characteristic of the first three approaches is therefore their emphasis on ‘culture’, at least in the labeling of their vision.

In the other three approaches the emphasis is not on ‘culture’ (as the presumed cause of problems) but on ‘equity’ or ‘equality’ (as the hoped-for result of efforts to tackle them). COER refers to “equitable access to health care of appropriate quality”: in relation to service delivery, it speaks of “improving the adaptation of health service provision to the needs, culture and social situation of migrants”. EDS does not provide a definition of its concept of equality, but relates it to the pursuit of quality, which in turn is defined as recognizing the needs and circumstances of all (both patients and staff) and...
ensuring accessibility, appropriateness, safety and effectiveness for patients. EQS explicitly distances itself from the concept of ‘cultural competence’, instead highlighting Whitehead’s definition of equity in health: “equal access to available care for equal need; equal utilization for equal need; equal quality of care for all” (22).

The target population of each approach refers to the user groups envisaged by the authors as beneficiaries. CLAS, JCR and CRF refer to the target population in terms of race, ethnicity, culture or language, while EDS and EQS also include gender, age, disability, religion, sexual orientation, transgender status (both EDS and EQS); marriage and civil-partnership, pregnancy and maternity, nationality (only EDS); socio-economic status and aboriginal status (EQS). COER focuses explicitly on migrants, a category that is not mentioned explicitly in CLAS, JCR, CRF or EDS. However, COER uses the term migrant “in a very broad sense, referring not only to those who change their country of residence voluntarily but also to asylum seekers, refugees and victims of human trafficking. Since the consequences of migration may also extend beyond the first generation, second and later generations are also discussed. In the case of Internally Displaced Persons, internal migrants are also included”. There is thus considerable overlap between the category of ‘migrants’ as defined by COER and the term ‘ethnic minorities’ used in other approaches.

‘Horizontal’ analysis (according to domains) (see table 7.2 at the end of this chapter)

1. Organizational commitment

Elements of the various approaches were classified in this domain if they mentioned commitment at management level to responsiveness to diversity. Two dimensions were found: policy and leadership and measurement of performance.

Policy and leadership

All six approaches maintain that organizations must make an explicit commitment to developing responsive care, rather than merely permitting individual initiatives that are not structurally imbedded in the organization. In COER this requirement is implied by insistence on a ‘whole organization approach’. Commitment can either take the form of an explicit plan (CLAS, EQS), which sets out how the organization intends to organize and guarantee responsiveness, or a policy of good leadership (JCR, EDS), or both (CRF).

‘Good leadership’ is explicitly committed to achieving responsive care and promotes this within the organization (JCR, EDS): leaders take responsibility for reaching this goal (CRF). All approaches emphasize that plans for change should be integrated in existing organizational policies and processes. EQS additionally promotes a ‘proactive’ approach: in all its plans, the organization should anticipate the effect the plans will have on accessibility and quality of care for vulnerable groups.
Measuring and improving performance

All approaches regard it as essential that organizations measure their performance in providing responsive services (e.g. outcomes of treatment for different groups), with the aim of identifying necessary improvements, taking action, and assessing the organization’s progress in providing responsive care. CLAS, EDS and EQS further emphasize that performance measurement should be a continuous activity, incorporated in regular performance measurement systems. The approaches differ in the variables which they suggest should be measured: some focus on quality of care, some on accessibility, and some on both (see also the domain ‘collecting data’ for the data-sources to be used in measuring and improving performance). CRF is the only approach stipulating mandatory indicators for measuring organizational cultural responsiveness. These have to be submitted by affiliated organizations and are also used for benchmarking.

2. Collecting data

The second domain we identified concerns the collection of data, not as an end in itself but because these data are necessary to measure equity of access and quality of care and to identify special needs or opportunities for improvement (see also the domain ‘measuring and improving performance’). Two types of data are distinguished: one concerns the population at large; the other concerns the organization’s own users.

Data on the population at large

Five approaches (CLAS, JCR, CRF, EDS, EQS) recommend assembling data on the community or catchment area in order to adapt services to the needs thus identified. Organizations can use information that is already available, but CLAS and EDS also give organizations an active role in collecting these data themselves. Such data include demographic variables (e.g. age, gender, ethnicity), characteristics potentially affecting service use (e.g. language proficiency, health literacy), health status and exposure to health risks. In COER the importance of empirical evidence is strongly emphasized: governments are urged to collect it “in partnership with relevant organizations”.

Data on the patient population

Patients’ files can serve as a source of data on ethnicity, race, language and other characteristics considered relevant for quality of care. For CLAS, JCR, CRF, and EQS these data are considered important in order to identify and monitor health and health care inequalities. For CLAS, JCR and EQS, information in patients’ files on individual characteristics associated with ethnic minority status (e.g. proficiency in the majority language) also enables adaptation of care to the needs of an individual patient. Additionally CLAS, JCR, CRF, EDS and EQS emphasize that outcome measures and patient
feedback systems must be able to analyze results according to diversity characteristics. The approaches differ in the types of data they recommend organizations to collect.

3. Staff/Workforce

The third domain concerns the staff or workforce of the organization. Two dimensions can be distinguished: staff competencies and diversity in the workforce.

Staff competencies

Staff competencies in delivering responsive care, and the importance of education and training, are central themes in all approaches. CRF and EDS describe a comprehensive approach to improving confidence and competence among staff, for example through personal development programs (EDS) and adapted HRM policies (CRF). CLAS, CRF, COER and EQS emphasize that all staff should be trained (CLAS even includes affiliated and subcontracted staff); CLAS, CRF and EQS also recommend monitoring the effects of training. CLAS recommends separate training in the provision of responsive care, JCR recommends the incorporation of such training in the existing curriculum, while COER and EQS support both. The approaches vary in the amount of information they provide on the content of training.

Diversity in the workforce

According to CLAS, JCR and COER, diversity among staff members is desirable for furthering responsiveness to patient diversity. Two arguments are given for the importance of staff diversity. The first is general: the workforce should be representative of the general population (CLAS, COER). The second is more specific: staff diversity is considered to further equity by making possible a higher degree of linguistic and ethnic concordance between patients and staff (CLAS, JCR). EDS and EQS discuss this issue from the perspective of equality among staff and include objectives for inclusive Human Resource policies relating to issues such as recruitment. CRF does not address the issue of staff diversity.

4. Ensuring access

All issues relating to barriers to entering the healthcare organization were classified under this heading. The dimensions that emerged concerned entitlement to care, the provision of understandable information, and issues concerning geographical and other aspects of accessibility. Some issues discussed in this domain reappear in the domain of ‘care provision’, because they are also relevant to the caregiving relationship.

Entitlement to care

Entitlement to care (i.e. whether patients are insured or are allowed to use national health services) is not mentioned in CLAS, JCR, CRF and EDS. This is understandable to
the extent that entitlement is an issue covered by legislation and insurance rules, rather than by the policies of service providers. If service providers choose to give care outside the framework of formal entitlements, this is left to their own discretion. However, EQS goes a step further and charges organizations with a responsibility for patients who are not eligible for care: it urges that at the very least, steps should be taken to help them find appropriate care elsewhere. COER, which includes recommendations at health system level, makes a plea for “adequate entitlements to use of health services”: concerning the role of service providers, it stresses that these must ensure that legislation is implemented properly and that all care providers are aware of existing rights.

‘Understandable’ information

Three approaches (CLAS, COER and EQS) stress that organizations should provide ‘understandable’ information in order to facilitate accessibility. This means providing information which is translated where necessary and is adapted to the health literacy level of the targeted populations.

Geographical accessibility

The importance of reducing geographical barriers to accessibility is briefly discussed in COER and EQS.

Other aspects of accessibility

In EDS and EQS two unique dimensions related to accessibility appeared. Firstly, EDS mentioned specific types of care (public health, vaccination and screening programs); secondly, EQS discussed the accessibility of organizations for specific ‘disadvantaged’ target groups such as HIV/AIDS patients, disabled patients, and homeless people.

5. Care provision

Issues in this domain relate to the quality of care patients receive within an organization. Topics mentioned in the six approaches include: care that is responsive to the needs and wishes of patients, patient participation in the care process, overcoming communication barriers, providing ‘understandable’ patient information materials, trust, and patients’ rights.

Care responsive to needs and wishes

All approaches underline the importance of this issue. The interpretation of this dimension is related to the different visions the approaches have concerning the nature of responsive care. ‘Needs’ are discussed in various ways:

- CLAS and CRF focus on the cultural needs of patients, in accordance with their respective visions on responsive care (‘culturally competent’ and ‘culturally responsive’).
- JCR refers to ‘additional’ and ‘unique’ needs that should be integrated in the clinical process: “it is important for hospitals to be prepared to identify and address not just the clinical aspects of care, but also the spectrum of each patient’s demographic and personal characteristics”.

- COER focuses on the needs of migrants (broadly defined), going beyond cultural factors to consider social position, migration history and legal situation.

- EDS and EQS focus on needs resulting from patients’ individual characteristics.

- Apart from identifying needs, JCR also discusses the points in the care continuum at which they should be taken into account. Although all approaches emphasize the importance of taking patients’ needs and wishes into account, they leave it up to the professional to reconcile the demands that patients or their relatives may make with the dictates of their professional conscience.

Patient participation in the care process

Five approaches (JCR, CRF, COER, EDS) explicitly refer to the importance of patient participation or involvement in the individual care process, for example in shared decision making about treatment and care planning (23). CLAS and EQS do not refer explicitly to patient participation in this context; however, the standards they provide show that they too consider patients as active participants in their treatment.

Overcoming communication barriers in patient-provider contact

All approaches except EDS emphasize that organizations should systematically tackle language barriers in the service delivery setting, placing the onus on the organization to provide patients with language assistance where necessary. Various types of interpreting are recommended such as professional interpreters, bilingual staff or intercultural mediators; approaches differ according to which type they prefer. CLAS, JCR and COER explicitly advise against using untrained, informal interpreters such as family members. CLAS, JCR, CRF and EQS assert that organizations are responsible for ensuring the quality and competence of language assistance that is offered. CLAS and JCR mention that patients should be informed about their right to language assistance. JCR and EQS also discuss support to patients with other communication barriers (e.g. hearing or speech impairments).

Understandable patient information materials

With the exception of EDS, all approaches stress that patient information materials should be understandable for all patients, in terms of both language and level of health literacy. When suitable materials are not available, CLAS asserts that patients have a right to orally translated information. These points concern not only patient folders
providing information about specific medical problems or treatments, but also consent forms and labeling of medicines.

Trust

The approaches discuss several issues related to building trust between users and service providers. The first of these is related to the environment within the health care organization: CLAS, JCR and EQS stress the importance of making this welcoming and inclusive. Some approaches include statements underlining the security of patients, stressing that patients should not be exposed to any dangers and mistreatment that might arise from their vulnerability. Phrases used include “patients are free from abuse, harassment, bullying, violence” (EDS); and “the patient has the right to be free from neglect, exploitation, and verbal, mental, physical and sexual abuse” (JC Requirements (see Box 7.1), p.54 (16)).

A second issue related to trust concerns conflict and grievance procedures. CLAS and JCR recommend that these procedures should be capable of identifying issues that concern organizations’ responsiveness to diversity, and that such conflicts should be dealt with in a respectful manner (CLAS, JCR, and EDS). The issue of access by minority patients to grievance procedures is also discussed (CLAS, JCR), including the need for personnel dealing with complaints and grievances to receive proper training (CLAS).

Patients’ rights

CLAS and JCR discuss the importance of informing patients about their rights. This concerns (among other things) the right in the US to receive language assistance (CLAS, JCR) and not to experience discrimination (JCR). JCR and EQS also note the importance of adapting informed consent procedures to the patients’ needs (e.g. health literacy level).

6. Patient and community participation at organizational level

The sixth dimension identified in the approaches concerns the involvement of users and communities in health care at the organizational level. In this domain one dimension appeared: involving patients in the development of services. Patient participation in the care process was not subsumed under this domain.

Involving patients and communities in the development of services

The issue of participation at the organizational level is discussed by all approaches. The first argument put forward in favor of such participation is that it results in better responsiveness and quality of care (CLAS, JCR). Another advantage named is that patients and communities can contribute to the implementation of changes (EDS). The approaches explicitly (CLAS, CRF, COER, EDS, EQS) or implicitly (JCR) assume that their target populations often belong to disadvantaged groups that may normally be less likely
to take part in participation processes. The approaches therefore pay attention to the challenge of creating inclusive participation processes.

Four approaches explicitly mention patient as well as community participation (CLAS, JCR, CRF, EDS; COER speaks of migrant participation). The important difference between patient (or user) and community participation is that the latter brings in the voice of people who did not get into treatment. However, only CLAS and EDS explicitly regard it as important to build partnerships (e.g. with community representatives or organizations) in the community served by the health care organization. Their argument amounts to the following: a health care organization serves a community; therefore the community has to be enabled to exert influence on what happens in the organization through a collaborative process. In the other approaches patients and community members are regarded as complementing each other (usually in the same sentence), without making clear the additional value of community participation.

7. Promoting responsiveness

Issues were classified in this domain if they concerned the promotion of responsive health care in the wider society. We identified one dimension, ‘sharing information on experiences’ in improving care for ethnic minority patients.

Sharing information on experiences

All approaches except CRF mention the importance of sharing experiences in promoting responsiveness with the general public and the community. This is proposed with different aims in mind: to increase support for responsive care from the general public (COER), to demonstrate an organization’s commitment (CLAS, JCR), or to enable organizations to learn from each other (CLAS, EQS). CRF and EQS take this theme a step further, by proposing that organizations should enter into active partnerships with others that promote equity within the health care system (e.g. in research and other collaborative activities).

8. Unique issues

Two issues were unique to particular approaches. JCR repeatedly mentioned the identification and addressing of patients’ mobility needs (e.g. using a cane, guide dogs). EDS emphasized “supporting the workforce to remain healthy”, which is in line with its focus on equality in the workforce.

‘Vertical’ analysis (comparing approaches)

In the foregoing section we have discussed findings in terms of the domains which form the rows of the matrix in Table 7.2. In what follows, we analyze differences
between the approaches represented in the columns, in order to obtain insight into the specific nature of each approach.

1. As its name implies, CLAS focuses mainly on cultural and linguistic issues. The linguistic issues have a legal basis in the Civil Rights Act of 1964, which requires “entities that receive Federal financial assistance to take steps to ensure that limited English proficient individuals have meaningful access to the health services” (11), p. 10). Issues related to patients’ position in society are viewed in CLAS as aspects of culture, which is sometimes confusing. CLAS has a very explicit vision on responsive health care, for example in the details provided about the content of training or the types of data that should be collected. Although unequal access is mentioned as a problem which might be reduced by providing appropriate services, the separate CLAS standards discuss only linguistic barriers to access.

2. JCR follows the steps in the clinical care process, which is explained by its origin in the Joint Commission standards for hospitals. JCR was developed as a supplement to existing standards, so it may have left out some issues already covered by existing Joint Commission standards. The standards do not embody an elaborated vision on ‘responsiveness’ beyond the general terminology of cultural competence, communication, and patient- and family-centered care. Accessibility is not operationalized in JCR. Interestingly, we see that the international branch of the Joint Commission does consider accessibility as an important aspect of health care: in their international accreditation standards there is a specific standard on access to care and continuity of care. For example they have defined the following standard: “the organization seeks to reduce physical, language, cultural, and other barriers to access and delivery of services” (p.42 (24)).

3. CRF focuses, like CLAS, mainly on cultural and linguistic issues. Other issues affecting access to care are not mentioned. CRF offers quantitative and qualitative indicators (standards and measures) for measuring organizational responsiveness to diversity. In contrast to other approaches, it offers process indicators. The indicators provide organizations with relevant information for improving their services, and are also meant to yield information enabling health services to be compared with each other.

4. COER is at a different level, being addressed to governments rather than individual health care organizations. Governments are assumed to be ultimately responsible for everything that goes on in the health system. Issues concerning organizational responsiveness to diversity are discussed without specifying precisely the division of responsibilities between levels. In keeping with the Council of Europe’s historical role, COER is primarily concerned with the ethical and human rights dimensions of social and health issues.
5. EDS addresses issues concerning both accessibility and quality of care, but its vision of responsive care for ‘protected groups’ remains rather implicit. The implementation strategy elaborates on steps such as ‘engage with local interests’ and ‘analyze performance’. The content of responsive care is only briefly described in terms of goals such as ‘better outcomes for all’ and ‘improved patient access and experience’ (see Table 7.1). EDS does not provide an explicit definition of equality in care or a specification of how this should be realized in practice.

One of the main objectives of EDS was to provide a tool for NHS commissioners to comply with the UK’s ‘Public Sector Equality Duty’ (PSED). This is reflected in the envisaged target groups of EDS (the chosen ‘protected groups’ are the same as those to which the PSED applies), as well as in the unique focus of EDS on equality among staff (e.g. equal career changes, no harassment on the work floor) which is in line with the aim of the PSED to eliminate discrimination and enhance equal opportunities throughout the public sector. The issue of language is not discussed at all, as it is not discussed in the PSED. Also unique in EDS is the clear role that has been described for engagement of patients and communities within the whole implementation strategy.

6. EQS focuses on quality of care and access, which are both aspects of healthcare equity. Its emphasis is on the vulnerability of certain patients, which can result from many factors – ‘culture’ being hardly mentioned as one of these. The focus is on patients’ individual needs and characteristics, rather than their membership of specific ethnic, cultural or other groups. This approach seems to view ‘patient centered care’ as the best way to respond to diversity in care provision. Although EQS defines its target group as ‘migrants and other vulnerable groups’, most of the standards focus on issues relevant to migrants, which is explained by the Task Force’s origin in the Migrant Friendly Hospital network (25).

Variations in the orientation of different approaches

Looking at the differences between approaches, we see that only the European ones address issues of access to health care in the sense of entitlement. A common feature of the non-European approaches is their emphasis on ‘culture’. On closer examination, this seems to be mainly a question of how factors are labeled: sometimes it turns out that factors such as socioeconomic or legal status are regarded as ‘cultural’ ones. In the European approaches the issue of culture receives less emphasis: EQS, for example, hardly mentions it as a topic of importance. Here the focus is on individual characteristics, which brings EQS close to the approach known as ‘patient centered care’ (26) (Saha, Beach, and Cooper have discussed the relation between ‘patient centered’ and ‘culturally competent’ care (27)). A possible shortcoming of this individualistic
perspective is that the social position that characterizes members of certain vulnerable
groups (e.g. asylum seekers, irregular migrants) may be overlooked. However, COER and
EQS are the only approaches that explicitly refer to ‘migrants’ and take into account the
vulnerability that results from having different kinds of migrant status (asylum seeker,
irregular migrant, labor migrant etc.).

Discussion and conclusion

Through a qualitative analysis of six current approaches to organizational
responsiveness to the diversity of users, we developed an over-arching framework and
subjected the content of different approaches to a comparative analysis. It emerged that
the following ‘domains’ were almost universally regarded as important for creating
responsive organizations: organizational commitment, collecting data to provide
empirical evidence on inequalities and needs, development of a competent and diverse
workforce, ensuring access for all users, ensuring responsiveness in care provision,
fostering patient and community participation, and actively promoting the ideal of
responsiveness. Almost all these issues could be recognized to some extent in all the
approaches that were analyzed.

With the exception of EDS and EQS, all approaches are primarily oriented to the
needs of ethnic minorities and/or migrants. Differences of language and culture play a
prominent role, especially in CLAS, JCR and CRF. Nevertheless, all approaches recognize
that many aspects of an individual’s social position can give rise to inequalities in health
care. EDS was specifically developed for a wide range of target groups (those covered by
the UK Equality Act). EQS explicitly aimed to address diversity from a broader
perspective; its vision seems heavily influenced by the notion of ‘superdiversity’ (28),
resulting in a strong emphasis on individual differences.

We also analyzed the extent to which the six approaches studied used the same
domains and dimensions. There were relatively few empty cells in the matrices shown in
Tables 2 and 3, which suggests a broad consensus regarding the essential issues. There
were, however, differences regarding the important ingredients of responsive care and
the measures regarded as necessary to improve accessibility. Variations in the
conceptualization of ‘responsive care’ reflect in part different assumptions about the
type of diversity that should be responded to. CLAS and CRF address the issue of racial or
ethnic groups differing in terms of language and/or culture. Patients tend to be identified
as members of a group, with little attention being paid to differences within groups. EDS
and EQS, on the other hand, adopt a more individualistic and multidimensional
approach; though aiming at ‘inclusiveness’, they steer away from definitions of diversity
in terms of group membership. For example, CLAS states that “care should be
compatible with cultural health beliefs and practices, and preferred languages”, whereas EQS states that “individual characteristics, experiences and living conditions are considered”. COER is explicitly focused on migrants (broadly defined) as a group, while mentioning a wide spectrum of issues that may be relevant to the provision of accessible and appropriate care.

The non-European approaches focus on improving quality of care and improving linguistic accessibility in the fight against health disparities, while the issue of ‘entitlement to care’ is overlooked. This is remarkable since (lack of) health insurance coverage explains substantial proportions of disparities in health care in the US (29). The National Health Interview Study 2012 found that while 7.6% of white respondents had been uninsured for more than one year, this percentage was 23.6 in the Hispanic population, 11.7 in the black population, and 11.3 in the Asian population (30). Although entitlement to care is a matter of health systems, approaches that aim to reduce disparities in health and health care should at least acknowledge the influence of this issue on disparities.

Our analysis has its limitations. First of all we based it on six approaches to organizational responsiveness to diversity. It was not our aim to compare all existing approaches, because too many have been developed. However, the six approaches that we included in this framework showed considerable consensus regarding the important elements of care that is responsive to diversity. The framework can be used to describe and compare other approaches. Secondly, the level of detail provided by the approaches varied. Classifying them in our framework might not fully do justice to the visions or ideas behind the approaches. For example, EDS is very concise in its conceptualization of responsiveness, but it may be that within the NHS other documents elaborate this concept in more detail.

Conclusion

To our knowledge this is the first systematic comparison of the content of approaches for organizational responsiveness to diversity in health care. Our framework showed that organizational responsiveness to diversity in health care means ensuring access and providing appropriate care. This in turn is dependent on meeting the following preconditions: demonstrating organizational commitment, collecting and using evidence on inequalities and needs, developing a competent and diverse workforce, fostering patient and community participation, and advocating for responsiveness.

Our analysis shows that there is considerable consensus among approaches concerning the way in which health service organizations should respond to diversity. There are differences between the approaches, but many of these do not so much reflect differences of viewpoint as variations in the emphasis that is placed on the
concept of ‘culture’. On closer inspection, this variation reflects different definitions of the concept: in some approaches it is linked to a wide range of attributes such as socioeconomic position, education, or sexual orientation. This enlarged concept of culture is particularly pronounced in the Enhanced CLAS Standards (7). However, we believe that stretching the concept of culture in this way is confusing (31), and the discussion on providing diversity-responsive health care would win in clarity if the various social dimensions of importance were clearly distinguished from each other.

The approaches included in the comparison are all to a greater or lesser extent focused on diversity in migrant and ethnic minority groups. Nevertheless, diversity is a characteristic of the population as a whole. The focus on responsiveness to diversity should be extended to all health service users (8). The concept of ‘patient centered care’ is a step in the right direction of acknowledging diversity among all patients. However, patient centeredness focuses on acknowledging the uniqueness (diversity) of patients, and is thus individualistic. The most serious inequities in health care are strongly associated with differences in group membership and social situation. For example, being an asylum seeker or undocumented migrant is neither a cultural characteristic nor a personal one – it is a social position, with important consequences for health and access to health care.

All in all this paper suggests a high degree of agreement between approaches (countries, institutions) on how health service organizations should respond to diversity. There is enough consensus in the field to enable us to move ahead in adapting health services to diversity with the aim of reducing health care inequities. This consensus creates the opportunity to move forward, to resolve issues regarding terminology and to help health care organizations to respond to the diversity that is present in modern societies. At the same time, we need to work as hard as possible to underpin these recommendations with research.
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<tbody>
<tr>
<td>US dept of Health and Human Services; Office of Minority health (U.S.)</td>
<td>The Joint Commission (U.S.)</td>
<td>Victorian Government; Dept. of Health (Australia)</td>
<td>Council of Europe; The committee of ministers (Europe)</td>
<td>The National Health Services (NHS); The Equality and Diversity Council (U.K.)</td>
<td>Health Promoting Hospitals; Task Force on Migrant-Friendly and Culturally Competent Health care (Europe)</td>
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<tr>
<td>AIM</td>
<td>*ensure equitable and effective treatment in a culturally and linguistically appropriate manner</td>
<td>*improve overall safety and quality of care</td>
<td>*better links between access, equity, quality and safety</td>
<td>*equitable access to health care of appropriate quality</td>
<td>*better outcomes for patients and communities, better working environments for staff</td>
<td>*ensure equitable and accessible health care</td>
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<tr>
<td></td>
<td>*correct inequities</td>
<td>*integrate concepts from communication, cultural competence and patient-centered care fields into hospitals</td>
<td>*better health outcomes for culturally and linguistically diverse (CALD) populations</td>
<td>*track organizations' improvement; align cultural responsiveness (CR) with existing standards; develop benchmarks</td>
<td>*improve equality performance</td>
<td>*reduce disparity in health care</td>
</tr>
<tr>
<td></td>
<td>*more responsive services</td>
<td>*elimination of racial and ethnic health disparities</td>
<td>*enhance cost effectiveness of service provision</td>
<td>*equitable access to health care of appropriate quality</td>
<td>*review equality performance</td>
<td>*an Equity self-assessment by health care organizations</td>
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<tr>
<td></td>
<td>*inform, guide and facilitate culturally and linguistically appropriate care</td>
<td>*inform, guide and facilitate culturally and linguistically appropriate care</td>
<td>*track organizations' improvement; align cultural responsiveness (CR) with existing standards; develop benchmarks</td>
<td>*equitable access to health care of appropriate quality</td>
<td>*a tool to comply to the ‘public sector Equality Duty’.</td>
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<tr>
<td>VISION</td>
<td>*cultural and linguistic competence</td>
<td>*effective communication (EC)</td>
<td>*cultural responsiveness (CR)</td>
<td>*improving the adaptation of health service provision to the needs, culture and social situation of migrants</td>
<td>*equality for patients and staff</td>
<td>*promoting equity</td>
</tr>
<tr>
<td></td>
<td>*culturally and linguistically appropriate services (CLAS)</td>
<td>*cultural competence (CC)</td>
<td>*cultural responsiveness (CR)</td>
<td>*improving the adaptation of health service provision to the needs, culture and social situation of migrants</td>
<td>*personal, fair and diverse services and workplaces</td>
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<td></td>
<td>*patient- and family-centered care (PFCC)</td>
<td>*cultural responsiveness (CR)</td>
<td>*cultural responsiveness (CR)</td>
<td>*improving the adaptation of health service provision to the needs, culture and social situation of migrants</td>
<td>*personal, fair and diverse services and workplaces</td>
<td></td>
</tr>
<tr>
<td>TARGET POPULATION</td>
<td>*inclusive of all patients</td>
<td>*no target group, recommendations address 'issues' in health care (e.g. language, culture etc.)</td>
<td>*culturally and linguistically diverse populations (CALD)</td>
<td>*migrants</td>
<td>*protected groups</td>
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<tr>
<td></td>
<td>*especially racial, ethnic, and linguistic populations that experience unequal access</td>
<td>*no target group, recommendations address 'issues' in health care (e.g. language, culture etc.)</td>
<td>*culturally and linguistically diverse populations (CALD)</td>
<td>*migrants</td>
<td>*migrants and all other vulnerable groups</td>
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<tr>
<td>*health care organizations, policymakers, accreditation agencies, purchasers, patients, advocates, educators, health care community in general</td>
<td>*hospitals</td>
<td>*all Victorian health services</td>
<td>*governments of CoE member states</td>
<td>*NHS commissioners and providers</td>
<td>*health care organizations</td>
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<tr>
<td>*14 standards in three types: mandates (4), guidelines (9), and recommendations (1)</td>
<td>*54 recommendations structured around main points along the care continuum</td>
<td>*6 standards across four domains, divided in measures and sub-measures (both quantitative and qualitative)</td>
<td>*14 recommendations, specified in 31 sub-recommendations.</td>
<td>*18 outcomes grouped into four goals; nine steps for implementation</td>
<td>*5 main standards, divided in sub standards and measurable elements</td>
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<tr>
<td>*3 themes: culturally competent care, language access services, and organizational supports for cultural competence</td>
<td>*aspects of the care continuum: admission, assessment, treatment, end of life care, discharge and transfer; organization readiness</td>
<td>*Standards: a whole organization approach; leadership; interpreters; inclusive practice; consumer/community involvement; staff. *4 domains: organizational effectiveness; risk management; consumer participation; effective workforce</td>
<td>*EDS goals: better health outcomes for all; improved patient access and experience; empowered, engaged, and well-supported staff; inclusive leadership at all levels</td>
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<tr>
<td>STRUCTURE</td>
<td>*54 recommendations structured around main points along the care continuum</td>
<td>*6 standards across four domains, divided in measures and sub-measures (both quantitative and qualitative)</td>
<td>*14 recommendations, specified in 31 sub-recommendations.</td>
<td>*18 outcomes grouped into four goals; nine steps for implementation</td>
<td>*5 main standards, divided in sub standards and measurable elements</td>
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<tr>
<td>*5 main standards, divided in sub standards and measurable elements</td>
<td>*main standards: equity in policy; equitable access and utilization; equitable quality of care; equity in participation; promoting equity</td>
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### Table 7.2 The approaches inserted in the analytic framework

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<thead>
<tr>
<th>DOMAINS &amp; dimensions</th>
<th>CLAS</th>
<th>JCR</th>
<th>CRF</th>
<th>COER</th>
<th>EDS</th>
<th>EQS</th>
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<tr>
<td><strong>ORGANIZATIONAL COMMITMENT</strong></td>
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<tr>
<td><strong>Policy and leadership</strong></td>
<td>*a written strategic plan to provide culturally competent care&lt;br&gt;*strategic plan is integrally tied to the organization's mission, principles, service focus</td>
<td>*demonstrate leadership commitment to effective communication (EC), cultural competence (CC), and patient- and family centered care (PFCC)&lt;br&gt;*integrate concepts of EC, CC, PFCC into existing policies</td>
<td>*implement a Cultural Responsiveness (CR)-plan addressing the standards&lt;br&gt;*integrate CR-plan into existing services’ plans and processes&lt;br&gt;*demonstrate leadership&lt;br&gt;*have an advising structure with participation of culturally and linguistically diverse (CALD) populations&lt;br&gt;*allocation of financial resources&lt;br&gt;*employ a cultural diversity staff member when CALD population &gt; 20%</td>
<td>*organization as a whole must be ‘culturally competent’&lt;br&gt;*implement the recommendations in a sustainable, coordinated and evidence based way</td>
<td>*leaders conduct and plan business so that equality is advanced&lt;br&gt;*managers support and motivate staff to work culturally competent&lt;br&gt;*recruit, develop and support strategic leaders to advance equality outcomes&lt;br&gt;*integrate equality objectives into mainstream business planning</td>
<td>*a specific plan to promote equity, integrated with existing accountability systems&lt;br&gt;*all organization plans promote equity</td>
</tr>
<tr>
<td><strong>Measuring and improving performance</strong></td>
<td>*initial and on-going self-assessment of CLAS-related care&lt;br&gt;*integrate CLAS-related measures into regular quality improvement programs (e.g. internal audits)&lt;br&gt;*use data on individual patients for needs assessment, service planning and quality improvement</td>
<td>*a baseline assessment whether organization meets unique patient needs</td>
<td>*obligatory reporting on CR performance (on defined measures)&lt;br&gt;*perform research in outcomes (e.g. emergency presentations) for CALD patients’ care needs&lt;br&gt;*analyze quality/risk management data for CALD patients&lt;br&gt;*report on CR performance in organization’s regular performance reports&lt;br&gt;*include CALD stakeholders in performance review</td>
<td>*evaluate existing services, identify existing problems, develop good practices&lt;br&gt;*conduct research to identify problems, determine actions and evaluate interventions</td>
<td>*analyze performance, agree (with stakeholders) on results, and prepare equality objectives</td>
<td>*continually identify and monitor access and barriers in access, and evaluate interventions for reducing access barriers (e.g. communication support services)&lt;br&gt;*use data on equity performance to improve equity in accessibility and quality</td>
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<td>DOMAINS &amp; dimensions</td>
<td>CLAS</td>
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<td>CRF</td>
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<td>COLLECTING DATA</td>
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<tr>
<td>Data on the population at large</td>
<td>*maintain a current demographic, cultural and epidemiological profile, and a needs assessment of the community</td>
<td>*use available population-level demographic data of surrounding community</td>
<td>*monitor community profile and demographics</td>
<td>*governments (in partnership with other relevant organizations) collect background data and epidemiological data on migrants</td>
<td>*assemble evidence drawing on existing information systems (incl data on population level)</td>
<td>*collect or have access to data on health status and health inequalities of catchment area</td>
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<tr>
<td>Data on the patient population</td>
<td>*collect data on individual patient's race, ethnicity, spoken/written language in health record</td>
<td>*develop a system to collect patient-level data</td>
<td>*develop appropriate information strategies for data collection, reporting and sharing</td>
<td>*collect CALD patient satisfaction data</td>
<td>*assemble evidence including surveys of patient experiences</td>
<td>*organization's systems can measure equity performance</td>
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<td>STAFF/WORKFORCE</td>
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<tr>
<td>Staff competencies</td>
<td>*all staff receive on-going education in providing CLAS</td>
<td>*new and existing training addresses issues of EC, CC, PFCC</td>
<td>*provide staff at all levels with opportunities to enhance their CR</td>
<td>*train staff</td>
<td>*care professionals at various levels should be trained in accessibility issues and in cultural competence</td>
<td>*enable staff to be confident and provide appropriate care with support by training, personal development and performance appraisal</td>
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| STAFF/WORKFORCE      |      |     |     |      |     |     |
| Staff competencies   | *all staff receive on-going education in providing CLAS | *new and existing training addresses issues of EC, CC, PFCC | *provide staff at all levels with opportunities to enhance their CR | *train staff | *care professionals at various levels should be trained in accessibility issues and in cultural competence | *enable staff to be confident and provide appropriate care with support by training, personal development and performance appraisal | *all staff is aware and competent to address inequities due to education | *specific training on equity issues | *include equity issues in organization's core education |

*COLLECTING DATA

- *maintain a current demographic, cultural and epidemiological profile, and a needs assessment of the community
- *use available population-level demographic data of surrounding community
- *monitor community profile and demographics
- *governments (in partnership with other relevant organizations) collect background data and epidemiological data on migrants
- *assemble evidence drawing on existing information systems (incl data on population level)
- *collect or have access to data on health status and health inequalities of catchment area

*STAFF/WORKFORCE

- *all staff receive on-going education in providing CLAS
- *new and existing training addresses issues of EC, CC, PFCC
- *provide staff at all levels with opportunities to enhance their CR
- *train staff
- *CR references included in HRM policies and practices (e.g. position description)
- *communication systems for sharing information on CR
- *care professionals at various levels should be trained in accessibility issues and in cultural competence
- *enable staff to be confident and provide appropriate care with support by training, personal development and performance appraisal
- *all staff is aware and competent to address inequities due to education
- *specific training on equity issues
- *include equity issues in organization's core education
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<th>COER</th>
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<tr>
<td>Diversity in workforce</td>
<td>*strategies to recruit, retain and promote diverse staff, representative of demographic characteristics of service area</td>
<td>*recruitment efforts to increase a diverse workforce that reflects the patient population</td>
<td>*recruitment policies should ensure that the diversity of general population is reflected in the workforce (mentioned as an example)</td>
<td>*fair selection processes to increase diversity of all workforce</td>
<td>*fair and equitable workforce policies and practices</td>
<td>*monitor situations of people that are ineligible for care</td>
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<td>*diverse staff at all levels, including diverse leadership</td>
<td>*diverse workforce can increase ethnic and language concordance, which may improve communication</td>
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<td>*equality in levels of pay</td>
<td>*promote respect for dignity of all staff and volunteers</td>
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<tr>
<th>ENSURING ACCESS</th>
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<tr>
<td>Entitlement to care</td>
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<tr>
<td>'Understandable' information</td>
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<td>Geographical accessibility</td>
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<td>CORE</td>
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<tr>
<td><strong>DOMAINS &amp; dimensions</strong></td>
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<tr>
<td><strong>Care responsive to needs and wishes</strong></td>
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<td><strong>Inclusive practice in care planning (including dietary, spiritual and other cultural practices)</strong></td>
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<tr>
<td><strong>Throughout the care continuum</strong></td>
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<tr>
<td><strong>In inclusive practice in care planning (including dietary, spiritual and other cultural practices)</strong></td>
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<td>DOMAINS &amp; dimensions</td>
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<tr>
<td>Patient participation in the care process</td>
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<td>Overcoming communication barriers in patient-provider contact</td>
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<td>DOMAINS &amp; dimensions</td>
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<tr>
<td>‘Understandable’ patient information materials</td>
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<td>Conflict &amp; grievance</td>
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<tr>
<td>DOMAINS &amp; dimensions</td>
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<tr>
<td>Patients' rights</td>
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<tr>
<td>PATIENT AND COMMUNITY PARTICIPATION AT ORGANIZATIONAL LEVEL</td>
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<tr>
<td>Involve patients and communities in the development of services</td>
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*accommodate patients' diverse needs in informed consent procedure

*agree roles with local authority (e.g. services that share the same clientele)

*use feedback to improve services and share results of participation with public
<table>
<thead>
<tr>
<th>DOMAINS &amp; dimensions</th>
<th>CLAS</th>
<th>JCR</th>
<th>CRF</th>
<th>COER</th>
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<tr>
<td><strong>PROMOTING RESPONSIVENESS</strong></td>
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<tr>
<td>Sharing information on experiences</td>
<td>*make information available to public on progress and innovations in implementing CLAS *inform community, own organization (for institutionalizing CLAS) and other organizations to learn from each other</td>
<td>*share information with surrounding community about efforts to meet unique patients’ needs to demonstrate commitment</td>
<td>*undertake research to develop new and improved initiatives and resources for CR</td>
<td>*inform public adequately about issues concerning migrant health</td>
<td>*share assembled evidence on equality performance with local interests (e.g. patients, communities), so they can take part in analysing performance and set goals *publish accomplishments (grades) and equality objectives so they are accessible for local interests</td>
<td>*be a participant in networks, research initiatives which promote equity *disseminate results of research/practice related to equity *build solid relationships/networks with community-based service providers *ensure that equity is reflected in all partnership and service contracts</td>
</tr>
<tr>
<td><strong>UNIQUE ISSUES</strong></td>
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<td></td>
<td>*identify and address mobility needs (e.g. cane, guiding dogs)</td>
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<td>*support workforce to remain healthy, focus on major health and lifestyle issues that affect individual and wider population</td>
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<tr>
<td>DOMAINS &amp; Dimensions</td>
<td>CLARIFICATION OF THE DOMAINS AND DIMENSIONS</td>
<td>CLAS</td>
<td>JCR</td>
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<tr>
<td><strong>ORGANIZATIONAL COMMITMENT</strong></td>
<td>The obligations health care organizations impose on themselves about providing diversity responsive care.</td>
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<tr>
<td>Policy and leadership</td>
<td>Organizations’ explicit commitment to provide diversity responsive care, demonstrated in policies and leadership and integrated in regular policies.</td>
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<tr>
<td>Measuring and improving performance</td>
<td>Measuring organizations’ performance related to diversity responsive care and improving performance based on the findings.</td>
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<tr>
<td><strong>COLLECTING DATA</strong></td>
<td>Collecting data to provide evidence on equity of access and of quality of care for diverse populations.</td>
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<tr>
<td>Data collection on the population at large</td>
<td>Data collection on demographics, characteristics relevant for service use, and health of the population living in the geographical area served by the health care organization.</td>
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<tr>
<td>Data collection on the patient population</td>
<td>Data collection of the patients being served by the health care organization.</td>
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<tr>
<td><strong>STAFF/WORKFORCE</strong></td>
<td>Issues related to the care providers, the management and support workers, that work at a health care organization.</td>
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<tr>
<td>Staff competencies</td>
<td>Improving competencies of staff working at a health care organization to provide responsive care (e.g. by training and other support).</td>
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<tr>
<td>Diversity in workforce</td>
<td>Creating a demographically diverse workforce of a health care organization and ensure equal opportunities among all.</td>
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<tr>
<td><strong>ENSURING ACCESS</strong></td>
<td>People that need healthcare can access health care services in a timely manner and without barriers.</td>
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<tr>
<td>Entitlement to care</td>
<td>Implementation of legislation on entitlements for the use of health services for specific groups (e.g. undocumented migrants).</td>
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<td>‘Understandable’ information</td>
<td>Providing information adapted to language and health literacy needs of diverse patient populations to facilitate access.</td>
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<tr>
<td>Geographical accessibility</td>
<td>Reducing geographical barriers to access.</td>
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<td>Other aspects of accessibility</td>
<td><em>Issues on ensuring accessibility not discussed in the dimensions above</em></td>
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<td><strong>CARE Provision</strong></td>
<td>Providing good quality health care in the context of patients’ diversity.</td>
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<tr>
<td>Care responsive to needs and wishes</td>
<td>Providing care that is responsive to diverse patients’ needs and wishes.</td>
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<td>Patient participation in the care process</td>
<td>Patient participation or involvement in the individual care process.</td>
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<td>Overcoming communication barriers in patient-provider contact</td>
<td>Removing communication barriers in the patient-provider contact.</td>
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<tr>
<td>‘Understandable’ patient information materials</td>
<td>Removing barriers in understanding patient information materials (with regard to language and health literacy level).</td>
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<tr>
<td>Trust</td>
<td>Building trust between service users and service providers with regard to patient diversity.</td>
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<td>Patients’ rights</td>
<td>Inform patients of their rights.</td>
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<td>DOMAINS &amp; Dimensions</td>
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<tr>
<td>PATIENT AND COMMUNITY PARTICIPATION AT ORGANIZATIONAL LEVEL</td>
<td>The process that enables patients and/or communities to participate in planning, developing and delivering health services at organizational level.</td>
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<tr>
<td>Involving patients and communities in the development of services</td>
<td>Efforts to include all patients and communities (including those of risk to be excluded) in participation activities for development of services.</td>
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<td>PROMOTING RESPONSIVENESS</td>
<td>Furthering responsive health care in the society to which a health care organization belongs.</td>
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<tr>
<td>Sharing information on experiences</td>
<td>Disseminating experiences with providing diversity responsive health care to stakeholders/society.</td>
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*(shaded cells visualize that this dimension is not covered by the approach)*
References


