Cultural responsiveness framework

Guidelines for Victorian health services

A Victorian Government initiative

Victoria The Place To Be

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Contents

Glossary

Adverse event	An incident in which harm resulted to a person receiving healthcare (Department of Human Services, 2009)
Consumer	A current or potential user of a health service. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socioeconomic status and social circumstances, sexual orientations and health and illness conditions (Department of Human Services, 2006).
Communities	Groups of people who have interests in the development of an accessible, effective and efficient health and aged care service that best meets their needs (Department of Human Services, 2006).
Cultural and linguistic diversity (CALD)	Refers to the range of different cultures and language groups represented in the population who identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home (Department of Human Services, 2006).
Cultural competence	A set of congruent behaviours, attitudes and policies that come together in a system or agency or among professionals that enable that system, agency or those professionals to work effectively in cross-cultural situations (Cross, et.al. 1989).
Cultural responsiveness	Cultural responsiveness describes the capacity to respond to the healthcare issues of diverse communities.
Framework	A set of principles and long term goals that form the basis of guidelines and overall direction to planning and development (Department of Human Services, 2009).
Measures	Indicators which enable organisations to track and assess progress. Some are quantitative and include a numerator and denominator.
Quality	Doing the right things, for the right people, at the right time and doing them right the first time (Department of Human Services, 2009).
Safety	A state in which risk has been reduced to an acceptable level (Department of Human Services, 2009).
Standards	General statements against which organisations can audit their performance. The Australian Council of Healthcare Standards (ACHS) defines standards as “a statement of the level of performance to be achieved” (ACHS 2006).
Sub-measures	Additional guides towards achieving the measures.

1. Executive Summary

The cultural and linguistic diversity of Australia is well documented. According to the *2006 Census of Population and Housing,* 23.8% of Victorians were born overseas. Victorians came from over 230 countries, speaking over 200 languages. Over 20% of the population spoke a language other than English at home. Against this demographic backdrop, governments, both at state and federal levels, have developed policy and legislative frameworks for health care which clearly stipulate the need for health service systems and health professionals to become more culturally responsive in order to ensure quality heath care provision for the whole population.

In 2008 the Statewide Quality Branch then part of the Department of Human Services, now the Department of Health (the department) commissioned a *Review of cultural and linguistic diversity and cultural competence reporting requirements, minimum standards and benchmarks for Victorian health services.* This review was undertaken by the Institute for Community, Ethnicity and Policy Alternatives (ICEPA) at Victoria University.

The project was undertaken in a number of stages. It included a comprehensive literature review, consultations with departmental staff, and a diverse range of health services in metropolitan, rural and regional areas, as well as focus groups with cultural diversity committee members. A draft framework was developed and tested with health services through a statewide workshop and further feedback mechanisms.

The project revealed the following key constraints for cultural responsiveness:

- diverse levels of knowledge and understanding of cultural competence in health service settings
- absence of a whole-of-organisation approach to delivering culturally responsive services
- insufficient alignment between risk management, patient safety, quality improvement initiatives and cultural responsiveness
- a lack of integration of cultural diversity knowledge with practical strategies for patient-centred care
- challenges in managing the multiple planning and reporting requirements for cultural diversity
- absence of clearly specified cultural diversity standards, indicators and benchmarks, and effective assessment tools to measure performance.

From the consultations, literature review and the project findings, a cultural responsiveness framework was recommended to replace the health service cultural diversity plans (HSCDPs). The department recognises that many health services are currently implementing important initiatives and strategies for culturally responsive health service delivery. This new framework aims to

consolidate the achievements of the HSCDPs to date and to improve and extend cultural responsiveness performance.

This guide outlines the newly endorsed *Cultural responsiveness framework for Victorian health services.* The framework encompasses a strategic and whole-of-organisation approach and is designed to be aligned with health services' strategic planning processes. It is based on the four key domains of quality and safety: organisational effectiveness; risk management; consumer participation; and effective workforce, which are congruent with the *Victorian clinical governance policy framework 2009*.

The cultural responsiveness framework addresses the aforementioned constraints by articulating *six standards,* outlined in Table 1, for culturally responsive practice and by specifying key performance improvement measures to achieve the standards over time.

Table 1. Standards for cultural responsiveness

Standard 1 A whole-of-organisation approach to cultural responsiveness is demonstrated
Standard 2 Leadership for cultural responsiveness is demonstrated by the health service
Standard 3 Accredited interpreters are provided to patients who require one
Standard 4 Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices
Standard 5 CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis
Standard 6 Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness

It aims to consolidate the multiple cultural diversity reporting requirements for health services. The Statewide Quality Branch will accept one plan to be submitted by 30 November 2010. Reporting on the achievements of the plan will continue to take place annually, through the health services' *Quality of care report.*

Further information about the review, including the literature review and final report may be found at http://www.health.vic.gov.au/cald

2. Background

2.1 Health service cultural diversity plans

The Victorian Government introduced the Health Service Cultural Diversity Plans (HSCDP) initiative, in line with the goals and measures outlined in the Government's overarching policy document, *Growing Victoria together: A vision for Victoria to 2010 and beyond* (Victorian Government 2005), the *Cultural diversity guide* (Department of Human Services, 2004) the *Language services policy* (Department of Human Services, 2005), and the *Multicultural Affairs Act, 2004.* In 2006 all Victorian health services were required to:

- establish a cultural diversity committee as appropriate to the health service
- develop and implement a health service cultural diversity plan
- lodge the plan with the Director, Statewide Quality Branch
- report annually from 2007 on the accomplishments of the plan through the *Quality of care report*.

The purpose of the HSCDP was to improve the quality of service delivery and ensure that health services cater appropriately to culturally and linguistically diverse (CALD) communities. The plan was to be supported by a cultural diversity committee (CDC) acting as the focal point for the service's plan, including its development, implementation, monitoring, reporting and evaluation. The HSCDP was based on the following six minimum reporting requirements outlined in the department's *Cultural diversity guide*:

- understand clients and their needs
- establish partnerships with multicultural and ethno-specific agencies and CALD communities
- build a culturally diverse and culturally competent and responsive workforce
- use language services to best effect
- encourage participation in decision making
- promote the benefits of a multicultural Victoria.

2.2 Reviewing the HSCDP

The Statewide Quality Branch, during the first quarter of 2007, undertook an informal consultation with 14 metropolitan and five large regional health services on the development and implementation of HSCDPs. This was informed by a review of the 84 plans submitted to the branch. The guidelines for HSCDPs were not intended to be prescriptive. Health services had flexibility to develop a cultural diversity plan that responded most appropriately to the needs of their communities and their organisational capacity, structure and culture. A review of plans revealed considerable diversity in their scope, content, progress and implementation, identifying a need for greater clarification, support and guidance to health services.

In May 2008, the Statewide Quality Branch facilitated 'Present Practice – Future Opportunities', a statewide forum for health service providers and consumers. The forum provided an opportunity to: reflect on health services' experiences with the introduction and implementation of cultural diversity plans and CDCs; identify exemplars of good practice and areas for improvement; and identify future strategic priorities, including suggestions for revising the guidelines for HSCDPs. The report from the forum including key recommendations and the main findings is available for downloading at http://www.health.vic.gov.au/cald/hlth-service.

Through this process of review and analysis it became evident that improved guidelines, clearer standards and measures to improve health service responsiveness to CALD issues were imperative. In addition, there are considerable overlaps for health services in reporting on the HSCDP six minimum requirements and cultural diversity outcomes from other departmental program areas such as: Mental health - *Cultural diversity plan for Victoria's specialist mental health services;* Home and Community Care (HACC) *cultural planning strategy;* and Disability services *cultural and linguistic diversity strategy*. This has resulted in some health services having multiple reporting requirements on similar issues.

The Review project recommended a new Cultural responsiveness framework replace the HSCDP. Reporting by health services will commence in November 2010.

2.3 Continuity between HSCDPs and the Cultural responsiveness framework

As with its predecessor, the HSCDP, the Cultural responsiveness framework is intended to be used as a tool to further strengthen the capacity of health services to:

- consolidate and continue to identify key result areas and strategies for action to improve responsiveness to CALD issues in each health service
- embed CALD issues into the strategic planning process of the health service through better links with quality and safety improvement processes, the clinical governance policy framework, quality reporting and accreditation requirements and appropriate service delivery plans
- create a more culturally responsive health workforce
- deliver better health outcomes for culturally and linguistically diverse communities

- build a more rigorous evidence base for responsive and effective interventions, and the development of best practice benchmarks for the future
- continue to strengthen the Victorian Government's whole-of-government reporting framework on responsiveness to cultural diversity.

The intention of the Cultural responsiveness framework is to consolidate multiple requirements for reporting on cultural diversity initiatives within health services. It aims to strengthen and align planning and documentation with existing policy and reporting frameworks and accreditation processes, and support health services to work holistically and systematically on these issues by specifying clearer standards and measures for assessing achievement.

3. Overview of Cultural responsiveness framework

3.1 Principles

Given the cultural and linguistic diversity of Australia's population, it is increasingly incumbent on public health care services and health care professionals to ensure both equal access to, and the provision of, quality health care for the whole population. This requires that health services and health professionals are able to respond appropriately to the health needs of the diverse communities they serve.

The Cultural responsiveness framework is underpinned by the following principles:

1. Every person has the right to receive high-quality health care regardless of their cultural, ethnic, linguistic and religious background or beliefs.
2. Understanding and addressing the links between ethnicity, culture and language will improve health care for culturally and linguistically diverse communities.
3. Embedding cultural responsiveness in health care systems is a viable strategy to reduce disparities in health outcomes which may be exacerbated by cultural, language and religious differences.
4. CALD consumer, carer and community participation will enhance culturally responsive heath care delivery.

It is within the aforementioned principles that this Cultural responsiveness framework for health services has been developed.

3.2 Legislative and policy imperatives

The Cultural responsiveness framework supports existing departmental policy, legislation, clinical governance and quality and safety frameworks.

For example, the Victorian Government, the Department of Health, and the Department of Human Services have a long-standing commitment to multiculturalism and equal rights for all Victorians evidenced in policy and legislative requirements such as:

- *All of Us,* 2009
- *Victorian clinical governance policy framework,* 2009
- *Australian Charter of Healthcare Rights in Victoria,* 2009
- *A Fairer Victoria 2008: Strong People, Strong Communities,* 2009
- *Multicultural Victoria Amendment Act 2008*
- *The Charter of Human Rights and Responsibilities Act 2006*
- *Language services policy,* 2005
- *Cultural diversity guide,* 2004

Strategies for cultural responsiveness should be implemented within a quality and safety improvement framework. In its recent discussion paper on achieving the directions established in the proposed *National Safety and Quality Framework,* the Australian Commission on Safety and Quality in Healthcare includes as a key strategy - the provision of care 'that is culturally safe'. This could be achieved, it argues, through better understanding, and acting on, the links between adverse events and cultural safety, language services provision and the knowledge and skills of health professionals within health services.

3.3 Equity, access and quality

Equity in health care means that we all have the same right to access and receive high-quality and safe health care, regardless of cultural, linguistic and religious and socio-economic considerations. This does not mean that everyone receives the same care but rather that all persons have their health care needs equally well met, and that factors that can potentially contribute to differential patient outcomes (for example: access to accredited interpreters, culturally inclusive care), have been minimised (Weinick, et.al. 2008). A key argument in the literature is that the lack of culturally responsive care is in fact a major contributor to health disparities (National Quality Forum 2008).

The international research literature widely recognises that culture has significant influence in shaping peoples' perceptions of health and well being, as well as their experiences of health care (Johnstone & Kanitsaki, 2005; Kleinman et al, 1978; Brach & Fraser 2002). It is well documented that there are long-standing disparities in the health status of people from diverse cultural, linguistic and socio-economic backgrounds (Bacote, et al., 2007; Betancourt, et al, 2003; Flores, 2005; Divi, et. al, 2007).

Health disparities and lower quality care are exacerbated when health care organisations fail to address the links between ethnicity, culture and language in health service provision (Wilson-Stronks, et al., 2008). Moreover, there is strong evidence that people from diverse backgrounds, particularly patients with low English language proficiency, can receive poorer quality health care compared to mainstream patients, and are more likely to experience a 'trajectory of accident opportunity' and/or adverse events in their journey through the health system (Divi, et. al, 2007).

Advancing equality in healthcare is supported through the Australian Charter of Healthcare Rights in Victoria and the *Charter of Human Rights and Responsibilities Act 2006,* with which publicly funded healthcare services must comply.

3.4 Cultural responsiveness – a definition

The term *cultural responsiveness* has been used in preference to the term cultural competence for the following reasons:

- a lack of consensus as to the precise definition of cultural competence, despite a proliferation of cultural competence frameworks, tools and assessments
- consistency with government and departmental language in policy and legislative frameworks which specify the need for 'responsive service delivery' and that services should be 'responsive' to the needs of culturally and linguistically diverse communities.

The term ***cultural responsiveness*** refers to health care services that are *respectful of,* and *relevant to,* the health beliefs, health practices, culture and linguistic needs of diverse consumer/patient populations and communities. That is, communities whose members identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home.

Cultural responsiveness describes the ***capacity*** to respond to the healthcare issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organisational, professional and individual.

3.5 Benefits of Cultural responsiveness

Research suggests that providing culturally responsive health care has the potential to lead to improved:

- access and equity for all groups in the population
- consumer 'health literacy' and reduced delays in seeking health care and treatment
- communication and understanding of meanings between health consumers and providers resulting in:
  - better compliance with recommended treatment
  - clearer expectations
  - reduced medical errors and adverse events
  - improved attendance at follow-up appointments
  - improved consumer satisfaction
  - reduced hospitalisation rates
- reduced failure to attend and readmission rates
- consumer/patient satisfaction with health care
- patient safety and quality assurance
- public image of health service
- business practice and better use of resources (Stewart, 2006).

Cultural responsiveness thus may be viewed as a viable strategy to improve the links between access, equity, quality and safety, better health outcomes for culturally and linguistically diverse populations and as a strategy to enhance the cost effectiveness of health service delivery.

4. The framework

The Cultural responsiveness framework determines a minimum level of activity in four broad domains of quality and safety. These domains provide a structured mechanism to address issues identified from the overall project findings, including findings from the literature review; the consultations with health services; and feedback from the statewide workshop with health services staff. They are also specifically aligned to the domains of the *Victorian clinical governance policy framework,* 2009.

The absence of appropriate standards for cultural diversity initiatives within the Australian health system was a key project finding. The Cultural responsiveness framework provides six standards across the four quality and safety domains. Each standard has specified key measures for achievement. Some of these are quantitative in nature and include a numerator and a denominator. Others specify clear statements of what is to be achieved. Each standard and measure also identifies a series of sub-measures that serve as an additional guide for health services in achieving the key measures. These measures provide both qualitative and quantitative information to support the achievement of the standards.

The standards and measures have been designed to:

- assist health services to track their improvement processes
- better align planning, and documentation requirements with existing reporting, accreditation standards and measures
- contribute, *over time,* to the development of identifiable and achievable benchmarks for like health services.

The department understands that each health service has its own unique capacity, organisational structure, culture, service and client demographics. The Cultural responsiveness framework is a broad framework with clearly articulated minimum standards and measures that all health services can strive to achieve *over time*. They are designed to support health services to respond to culturally and linguistically diverse communities through a strategic coordination and planning process. Your health service may already have these or some of these standards in place.

Initial planning and development for cultural responsiveness should be framed against all six standards and the key measures under each standard. The Cultural responsiveness plan should encompass a strategic and whole-of-organisation approach, cover at least a three year period, and be aligned to the health services' strategic plan.

Where a health service has already undertaken considerable work in a particular area, the plan can note the achievements against the key measures and target higher level improvements in that area.

Where a health service identifies that new or additional work is required to achieve the key measures, specified sub-measures can be *identified* as the key measures for that particular health service for the specified reporting periods. This may be particularly relevant for small rural health services with small CALD client/consumer populations. In these situations the department would expect these health services, over time, to work towards achievement against the key measures specified under each standard.

Cultural responsiveness framework

4.1 Domain 1: Organisational effectiveness

There is considerable agreement in the research literature that culturally responsive health care cannot be effectively delivered without a systemic and whole-of-organisation approach (Betancourt, et.al.2002; Chrisman, 2007). It reveals that a key weakness in developing culturally responsive practices is the tendency to deal with cultural diversity in an ad-hoc way rather than developing high-level strategic governance structures and policies that can deeply embed culturally responsive practices across the whole of the health service. A key challenge, therefore, is that of repositioning cultural responsiveness from being 'bolted on' to organisational systems and management practices to being 'built in' as a core activity.

Leadership in cultural responsiveness recognises that the governance structure, the public health service board, the Chief Executive Officer, health professionals, clinical and organisational leaders and managers *all* share responsibility for and play a key role in planning, developing, implementing, monitoring and evaluating cultural responsiveness performance and achievements (National Quality Forum, 2009). As well, it is important to recognise health services' organisational culture and the role of the executive in "promoting and sustaining active attention to cultural factors in care" (Chrisman, 2007: 69).

Standard 1

A whole-of-organisation approach to cultural responsiveness is demonstrated

Measure 1

The following four policies, guidelines and processes are implemented:

1.1 The health service has developed and is implementing a Cultural responsiveness plan (CRP) that addresses the six standards of the framework

1.2 Reporting on the cultural responsiveness standards in the health services' *Quality of care report*

1.3 A functioning Community Advisory Committee (CAC), Cultural Diversity Committee (CDC), or other structure demonstrating CALD participation and input

1.4 Implementation of the Department of Human Services *Language services policy.*

Sub-Measures
Organisational guidelines and protocols that guide staff in working with CALD communities, consumers and carers.
Allocation and specification of financial resources for cultural responsiveness.
Development of appropriate information technologies and strategies for data collection, reporting and sharing information on cultural responsiveness.
Monitoring of community profile and changing demographics supported by employment of relevant in-house interpreters, appropriate translations and signage.
Partnerships with multicultural and ethno-specific community organisations in the area/region are developed and maintained.

Standard 2

Leadership for cultural responsiveness is demonstrated by the health service

Measure 2.1
Numerator: The number of senior managers who have undertaken leadership training for cultural responsiveness Denominator: The total number of senior managers

Sub-measures
An executive staff member has portfolio responsibility for cultural responsiveness and Key Performance Indicators (KPIs) against the Cultural responsiveness plan.
Employment of a cultural diversity staff member where 20% or more of health service patients are of CALD background.
Research opportunities are identified and undertaken to develop new and improved initiatives and resources for cultural responsiveness.
Training opportunities for senior managers on: • culturally responsive service delivery strategies • conducting organisational cultural assessments/audits.

4.2 Domain 2: Risk management

Providing healthcare that is culturally responsive and safe is a risk management strategy. Many culturally and linguistically diverse communities and Indigenous people do not feel safe accessing mainstream health services (Garret, 2008; Divi. et.al. 2007). Research within Australia clearly demonstrates the link between culture, language and patient safety outcomes (Johnstone & Kanitsaki, 2006). The implementation of the department's *Language services policy* and the provision of NAATI accredited interpreters in health settings has been well supported by Victorian health services. The delivery of safe high quality care is premised on effective communication between the consumer/patient and the health care provider. Limited English language proficiency is defined as the 'limited ability or inability to speak, read, write or understand the English language at a level that permits the person to interact effectively with healthcare providers or social service agencies'. Limited English language proficiency can adversely effect the communication process and the health outcome as well as infringe the rights of the consumer/patient.

In their pilot study of *Language Proficiency and Adverse Events in US Hospitals,* Divi et al (2007) firmly contend that an increasing evidence base is emerging to suggest that patient–provider communication is a serious patient safety concern and a common root cause of adverse events in healthcare delivery (Divi, et al. 2007). They describe the effects of language barriers as follows:

For consumers:

- limiting patient access
- undermining trust in the quality of the medical care received and the patient-health professional relationship
- compromising appropriate follow-up and care which may result in a 'trajectory of accident opportunity' for the patient
- misunderstandings and inadequate comprehension of diagnoses and treatment
- problems with informed consent
- dissatisfaction with care
- preventable morbidity and mortality
- disparities in prescriptions, test ordering and diagnostic evaluations.

For health professionals:

- inhibiting a clinician's ability to elicit patient symptoms which can result in an increased use of diagnostic resources or invasive procedures, inappropriate treatment and diagnostic errors.

For health systems:

- increased cost through unnecessary procedures or increased interventions to rectify errors.

Underutilisation of accredited interpreters, even when they are made available, commonly referred to as "getting by" has also been identified as another serious risk management issue (Diamond, et.al. 2008). As such, it is critical that health services accurately document and track the provision of language services (an accredited interpreter) during the clinical encounter and that patients who identify as requiring an interpreter in their preferred language are provided with one.

Standard 3

Accredited interpreters are provided to patients who require one

Measure 3.1

Numerator: Number of CALD consumers/patients identified as requiring an interpreter and who receive accredited interpreter services

Denominator: Number of CALD consumers/patients presenting at the health service identified as requiring interpreter services[1]

Measure 3.2

Numerator: Number of community languages used in translated materials and resources[2]

Denominator: Total number of community language groups accessing the service

1 Measure 3.1 It is important that health services clearly specify which data collection field they are using for this measure. For example, 'Interpreter required' or 'Preferred language'

2 Measure 3.2 can also incorporate translated materials accessed by the health service.

Sub-measures
Implementation of the Department of Human Services *Language services policy.*
Documentation of lack of provision of interpreters and reasons why (including face-to-face, telephone interpreting).
Audit of documentation of provision/use of interpreter in medical files.
Policies on consent include directions about the role of interpreters and family.
Feedback from patients on the use of interpreters in decisions about treatment and care planning.
Evidence of appropriate translations, signage, commonly used consumer/patient forms, education and audio visual materials, in languages other than English for predominant language groups utilising the service.
Quality/risk management committee (s) develop initiatives to track miscommunication errors for CALD consumers/patients.
Number of cases reported through 'adverse event' reports related to communication issues for CALD consumers/patients.
Number of complaints lodged by CALD consumers/patients.
Strategies in place to communicate with CALD consumers/patients even when the CALD demographics are low.
Research is conducted into outcomes of CALD patient care needs (for example comparative studies between English Speaking and Non-English Speaking patients regarding length of stay, emergency presentations, diagnostic tests, failure to attend appointments, evaluation of post consultation outcomes, etc.).

4.3 Domain 3: Consumer participation

Consumer participation and quality are reciprocal. Engaging consumers and patients as 'safety partners' with health service providers is gaining support as an effective strategy to identify and help prevent adverse events and improve patient safety outcomes (Johnstone & Kanitsaki, 2009). It is important that health services work with diverse consumers to increase individual and organisational awareness and understanding of the experiences of consumers and communities from culturally and linguistically diverse backgrounds to improve health service delivery and health outcomes.

Consumers, carers and community members from culturally and linguistically backgrounds face a number of specific barriers in accessing health care and optimising health outcomes.

These include:

- a lack of understanding of consumer/patient rights and responsibilities
- a lack of familiarity with the Australian health system. This is particularly relevant for recently arrived communities and refugees (who may continue to suffer health consequences as a result of refugee experiences including torture, trauma and deprivation in refugee camps)
- a lack of knowledge and confidence to: engage in participation, planning, monitoring and decision making activities, and to challenge the quality of care received, participate in client satisfaction surveys and or make complaints known to relevant health authorities.

These can be further exacerbated by: limited English language proficiency; inadequate language services provision; the impact of culture and belief systems; culturally constructed understandings of health, well being, treatment and compliance; a lack of cultural congruence between health professionals and consumers/patients; insufficient data; unequal partnerships with key culturally and linguistically diverse stakeholder groups; as well as systemic and organisational constraints within health service systems.

Standard 4

Inclusive practice in care planning is demonstrated, including but not limited to: dietary, spiritual, family, attitudinal, and other cultural practices

Measure 4.1

Numerator: Number of CALD consumers/patients who indicate that their cultural or religious needs were respected by the health service (as good and above)

Denominator: Total number of CALD consumers/patients surveyed on the Victorian Patient Satisfaction Monitor (VPSM) or other patient satisfaction survey[3]

Measure 4.2

Policies and procedures for the provision of appropriate meals (vegetarian, Halal, Kosher, etc.) are implemented and reviewed on an ongoing basis.

Sub-measures

Feedback from patients on the provision of information about their care and treatment is used to inform planning, development and review of services and support.

CALD patient satisfaction data collected and analysed (VPSM and other).

Consumer evaluation of cultural appropriateness of particular programs or services.

Development of and/or use of suitable instruments for assessment (clinical diagnosis and treatment) incorporating cultural considerations used by medical, clinical and allied health staff.

3 Measure 4.1 may not apply to small health services who do not receive a VPSM report. Alternative surveys and feedback processes may be specified.

Standard 5

CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis

Measure 5.1
CALD consumer membership and participation is demonstrated in the Community Advisory Committee (CAC) the Cultural Diversity Committee (CDC), or other specified structure.[4]

Sub-measures
Minutes of meetings show that the CAC/CDC or other specified structure has provided advice on planning and evaluation to the board (CAC) or executive (CDC) of the health service.
CALD consumer and stakeholder involvement in performance review and quality improvement processes.
Policies in place for facilitation of different degrees of participation from CALD consumers, carers and community members.

4 Consumer participation policies and strategies should be linked with those described in the *Doing it with us not for us* – Strategic Direction 2010-13.

4.4 Domain 4: Effective workforce

Professional development activities aimed at improving the cultural responsiveness capabilities of health professionals and health care organisations is recognised as a key strategy to improve outcomes for consumers, carers, communities as well as health care providers. Evidence provided through systematic reviews suggest that multifaceted interventions could lead to improved knowledge, attitudes and skills for health professionals, which, in turn, lead to improved patient satisfaction and improved patient health outcomes.

Providing culturally responsive care is not simply the memorisation of cultural facts, or a recipe book approach to understand key characteristics of specific culturally and linguistically diverse communities. It is not the sole domain of health professionals. Cultural responsiveness is everybody's business as health services need a culturally capable workforce to develop, implement and evaluate culturally responsive health care policy, programs and interventions. Health services are urged to establish more effective systems of workforce development to develop the cultural responsiveness capabilities of staff across all areas of the organisation including executive, management, health professionals and frontline staff.

Standard 6

Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness

Measure 6.1
Numerator: Number of staff who have participated in cultural awareness professional development[5] Denominator: Total number of employed staff within the current two year period

Sub-measures
Budget allocation for culturally responsive workforce development.
Suggested training opportunities for staff (i.e. admission, reception, clinical staff, management, executive) on: • provision of language services and use of interpreters (at commencement of employment, as part of orientation program) • culturally responsive service delivery strategies • conducting organisational cultural assessments/audits • conducting cultural assessments to understand consumer/patient's explanatory model for health and illness
Demonstrated post training staff evaluation on effectiveness and application of professional development.
Human resources management policies and practices include cultural responsiveness references in position descriptions, performance review and promotion.
Internal communication systems for sharing cultural diversity information and data are developed, maintained and periodically reviewed.

5 Measure 6.1 includes staff who have direct consumer/community contact, including frontline staff, clinical staff, and management who have a role in service planning, monitoring, review and evaluation.

5. Implementation

5.1 Planning for Cultural responsiveness

Planning for Cultural responsiveness should be as follows:

- The planning cycle should be at least three years and be clearly integrated into the health services' strategic planning cycle, strategic plan, quality improvement and accreditation processes (for example: Australian Council on Healthcare Standards, EQuIP4).
- A Cultural responsiveness plan should be developed by each health service. This may be done through the Cultural Diversity Committee, Community Advisory Committee, or other specified structure that specifies cultural responsiveness planning commitments in its terms of reference.
- The role of the Cultural Diversity Committee, Community Advisory Committee, or relevant structure must be clearly outlined to ensure that consumers, carers and community members participate in the planning, and evaluation process.
- Planning for cultural responsiveness should be against all six standards and the key measures under each standard set out in the framework.
- Where a health service has already undertaken considerable work in a particular area, the plan can note the achievements against the relevant measure and target higher levels of improvement in that area.
- Where a health service identifies that new or additional work is required to achieve the key measures, specified sub-measures can be *identified* to act as the key measures for that health service for that particular reporting period. This may be particularly relevant for small rural health services with small CALD client/consumer populations. *However, it is expected that over time health services will work towards achievement against the key measures specified under each standard.*
- The Cultural responsiveness plan should include strategies and anticipated outcomes as well as specified review dates against the standards and measures. A template is attached for planning and reporting purposes to the department. Please see Attachment D.
- The Cultural responsiveness plan should be endorsed by the public health service board.
- Each health service is required to lodge their first Cultural responsiveness plan to the Statewide Quality Branch by the ***30th of November 2010.***
- Reporting on the standards, measures and sub-measures will commence in the 2010-2011 *Quality of care report*. Please refer to the reporting timetable outlined on page 29 of this document.

5.2 Reporting on Cultural responsiveness

Reporting on the Cultural responsiveness plan should be as follows:

- Reporting on the achievements of the Cultural responsiveness plan is to take place annually, through the health services' Quality of care report.
- The report should outline the achievements, against the measures or sub-measures (where relevant) or the progress to date (including reasons for why standards and measures have not been met) in that year.
- The plan may be linked with other cultural diversity reporting obligations such as those specified below.
- For health services that complete numerous plans, the Statewide Quality Branch **will accept one plan.** For example, the cultural responsiveness plan may be amalgamated with the health services'
  - Community Participation Plan
  - HACC plan
  - Disability plan
  - Specialist Mental Health service plan
  - ICAP plan
  - Public sector residential aged care (PSRACS).
- Small rural health services with a small CALD population base can submit their primary cultural diversity reporting/planning requirement to the Statewide Quality Branch. For example a HACC plan.
- After due process within each health service, health services should make their Cultural responsiveness plan available on their website as well as their current Quality of care report.

5.3 Getting started

- Your health services' Cultural Diversity Committees, Community Advisory Committees or other relevant structure should familiarise itself with the standards, measures and sub-measures of the Cultural responsiveness framework.
- Identify where your health service is at in relation to the above by reviewing your current HSCDP and mapping key strategies and achievements across the standards and measures and sub-measures (See Attachment C for the links between the Cultural responsiveness framework and the HSCDP).
- Where applicable identify the links/overlaps with other plans and reporting requirements such as Community participation plan, HACC, etc.
- Consolidate your cultural diversity reporting requirements into one plan/process, identifying the most appropriate for your health service. This will be different for large and small health services. For example, metropolitan and regional health services with multiple reporting requirements may choose to consolidate their cultural responsiveness strategies into one Cultural responsiveness plan. (See Attachment B for the commonalities between each departmental cultural diversity reporting area, and Attachment D for the Cultural responsiveness plan template).
- Develop a draft Cultural responsiveness plan aligned to your health services' strategic planning process.
- Identify organisational supports and resources required for development.
- Discuss the Cultural responsiveness planning and reporting requirements within and across your health service, particularly ensuring communication and links with other cultural diversity reporting areas within your health service (CAC, HACC, Disability, Mental Health, ICAP and PSRACS).
- Discuss the Cultural responsiveness planning and reporting requirement with relevant external partners, stakeholders, multicultural and ethno-specific organisations.
- Implement a whole-of organisation approach to responding to the needs of culturally and linguistically diverse communities.

5.4 Reporting timetable

It is recommended that health services commence reporting on cultural responsiveness using the following staged reporting process as a ***minimum*** guide.

2010

A Cultural responsiveness plan is to be developed and lodged with the Statewide Quality Branch by 30 November. The plan is to cover at least a three year period and coincide with your health services' strategic planning cycle.

The plan should also indicate which other cultural diversity reporting requirements your health service reports against.

2010 – 2011 reporting period

Report in Quality of care report key achievements against the following as a minimum:
Standard 1: Measure 1.1
Standard 3: Measure 3.1 and Measure 3.2
Standard 5: Measure 5.1

2011- 2012 reporting period

Report in Quality of care report key achievements against the following as a minimum:
Standard 2: Measure 2.1
Standard 3: Measure 3.1 and Measure 3.2
Standard 4: Measure 4.1 and Measure 4.2
Standard 6: Measure 6.1

2012 - 2013 reporting period

Report in Quality of care report key achievements against all six standards and key measures.

- Standard 3: Measures 3.1 and 3.2 are deemed to be ongoing requirements and are to be reported on yearly.
- Where a health service has already undertaken considerable work in a particular area, the CRP can note the achievements against the primary measure and target higher levels of improvements in that area.
- Where a health service identifies that new or additional work is required to achieve the key measures, the sub-measures *can be identified* to act as the key measures for that health service for that particular reporting period.
- It is expected however, that over time the health services will work towards achievement against the primary measures specified under each standard.
- The Cultural responsiveness plan should reflect this developmental process and track achievements over time. As well, the reporting process should clearly illustrate the progress and continuity of practices.
- A separate review of the cultural responsiveness framework initiative will be conducted three years after its implementation in 2013-2014.

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Attachment A: Cultural responsiveness framework

Domain: Organisational effectiveness

Standard	Measure	Sub-Measures
1. A whole-of-organisation approach to cultural responsiveness is demonstrated	The following four policies, guidelines and processes are implemented: 1.1 The health service has developed and is implementing a Cultural responsiveness plan (CRP) that addresses the six minimum standards 1.2 Reporting on CRP six minimum standards in the *Quality of Care report* 1.3 A functioning CAC/CDC demonstrating CALD participation and input 1.4 Implementation of the Department of Human Services *Language services policy*	Organisational guidelines and protocols that guide staff in working with CALD communities, consumers and carers Allocation and specification of financial resources for cultural responsiveness Development of appropriate information technologies and strategies for data collection, reporting and sharing information on cultural responsiveness Monitoring of community profile and changing demographics supported by employment of relevant in-house interpreters, appropriate translations and signage Partnerships with multicultural and ethno-specific community organisations in the area/region are developed and maintained
2. Leadership for cultural responsiveness is demonstrated by the health service	2.1 The number of senior managers who have undertaken leadership training for cultural responsiveness ——————— The total number of senior managers	Executive staff member has portfolio responsibility for cultural responsiveness and Key Performance Indicators (KPIs) against CRP Employment of a cultural diversity staff member where 20% of health service patients are of CALD background Research opportunities are identified and undertaken to develop new and improved initiatives and resources for cultural responsiveness Training opportunities for senior managers on: • culturally responsive service delivery strategies • conducting organisational cultural assessments/audits

Domain: Risk management

Standard	Measure	Sub-Measures
3. Accredited interpreters are provided to patients who require one	3.1 Number of CALD consumers/patients identified as requiring an interpreter and who receive accredited interpreter services ——————— Number of CALD consumers/patients presenting at the health service identified as requiring interpreter services 3.2 Number of community languages used in translated materials and resources ——————— Total number of community language groups accessing the service	Implementation of the Department of Human Services Language services Policy Documentation of lack of provision of interpreters and reasons why (including face-to-face, telephone interpreting) Audit of documentation of provision/use of interpreter in medical files Policies on consent include directions about the role of interpreters and family Feedback from patients on the use of interpreters in decisions about treatment and care planning Evidence of appropriate translations, signage, commonly used consumer/patient forms , education and audio visual materials, in languages other than English for predominant language groups utilising the service Quality/risk management committee(s) develop initiatives to track miscommunication errors for CALD consumers/patients Number of cases reported through 'adverse event' reports related to

		communication issues for CALD consumers/patients Number of formal complaints lodged by CALD consumers/patients Strategies in place to communicate with CALD consumers/patients even when the CALD demographics are low Research is conducted into outcomes of CALD patient care needs (for example, comparative studies between English Speaking and Non-English Speaking patients regarding length of stay, emergency presentations, diagnostic tests, failure to attend appointments, evaluation of post consultation outcomes, etc.)

Domain: Consumer participation

Standard	Measure	Sub-Measures
4. Inclusive practice in care planning is demonstrated, including but not limited to: dietary; spiritual; family; attitudinal and other cultural practices	4.1 Number of CALD consumers/patients who indicate that their cultural or religious needs were respected by the health service (as good and above) _____ Total number of CALD consumers/patients surveyed on the VPSM or other patient satisfaction survey 4.2 Policies and procedures for the provision of appropriate meals (vegetarian, Halal, Kosher, etc.) are implemented and reviewed on an ongoing basis.	Feedback from patients on the provision of information about their care and treatment is used to inform planning, development and review of services and support CALD patient satisfaction data collected and analysed (VPSM and other) Consumer evaluation of cultural appropriateness of particular programs or services Development or use of suitable instruments for assessment (clinical diagnosis and treatment), incorporating cultural considerations used by medical, clinical and allied health staff
5. CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis	5.1 CALD consumer membership and participation is demonstrated in CAC/CDC/other specified structure	Minutes of meetings show that the CAC/CDC or other specified structure has provided advice on planning and evaluation to the Board (CAC) or Executive (CDC) of the health service CALD consumer and stakeholder involvement in performance review and quality improvement processes Policies in place for facilitation of different degrees of participation from CALD consumers

Domain: Effective workforce

Standard	Measure	Sub-Measures
6. Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness	6.1 Number of staff who have participated in cultural awareness professional development _____ Total number of employed staff within the current two year period	Budget allocation for culturally responsive workforce development Training opportunities for staff (i.e. admission, reception, clinical staff, management, executive) on: • provision of language services and use of interpreters (at commencement of employment, as part of orientation program) • culturally responsive service delivery strategies • conducting cultural assessments to understand consumer/patient's explanatory model for illness Demonstrated post training staff evaluation on effectiveness and application of professional development HR policies and practices include cultural responsiveness references in position descriptions, performance review and promotion Internal communication systems for sharing cultural diversity information and data are developed, maintained and periodically reviewed

Attachment B: Departmental cultural diversity reporting requirements

The department operates within the policy and legislative framework of the Victorian Government and is obliged to report to the Victorian Multicultural Commission as part of its multicultural reporting. A number of legislative frameworks govern the work of the department in relation to cultural diversity including:

- *Equal Opportunity Act 1995*
- *Racial and Religious Tolerance Act 2001*
- *Multicultural Victoria Amendment Act 2008*
- *Charter of Human Rights and Responsibilities Act 2006.*

In addition to the legislative requirements the department currently has six policy frameworks which require reporting on cultural diversity responsiveness. These are:

- *All of Us*
- *Cultural diversity guide*
- Health service cultural diversity plans
- Disability services cultural and linguistic diversity strategy
- Home and Community Care (HACC) *Cultural planning strategy*
- Cultural Diversity Plan for Victoria's Specialist Mental Health Services
- Aged Care Accreditation Standards as set out in the Quality of Care Principles.

The following table provides a summary of the current cultural diversity reporting and standards in the above areas. As can be seen from this table there are obvious similarities across the different reporting areas. These include: access; understanding the needs of clients; language services; and supporting a culturally competent workforce that can respond to client needs. The differences include issues of information and promotion (although this can be considered part of accessibility), consultation, partnerships with ethnic communities or multicultural agencies, service coordination and accountability.

DHS Overall	HSCDP	Disability	HACC	Specialist Mental Health Services	Public Sector Residential Aged Care Services
Cultural Diversity Guide	**Use of Cultural Diversity Guide**	**Service Standards**	**HACC Program Manual**	**The Cultural Diversity Plan for Victoria's Specialist Mental Health Services 2006-2010:**	**Aged Care Accreditation Standards**
1. Understanding clients and their needs 2. Partnerships with multicultural and ethno-specific agencies 3. A culturally diverse workforce 4. Using language services to best effect 5. Encouraging participation in decision making 6. Promoting the benefits of a multicultural Victoria	1. Understanding clients and their needs 2. Partnerships with multicultural and ethno-specific agencies 3. A culturally diverse workforce 4. Using language services to best effect 5. Encouraging participation in decision making 6. Promoting the benefits of a multicultural Victoria	1. Understanding people and their needs 2. Encouraging participation in decision-making 3. Providing culturally relevant and accessible information 4. A culturally diverse workforce 5. Using language services to best effect 6. Meeting the specific needs of different communities 7. Promoting the benefits of a culturally diverse Victoria	The HACC Cultural Planning Tool: • Access • Cultural relevance • Consultation • Information • Special needs programs • Service coordination, and • Accountability	• Delivering culturally competent mental health care • Incorporating cultural diversity into service and workforce planning • Providing access to high quality language services • Meeting the needs of refugees • Participating in cross-government and national initiatives to promote mental health in ethnic communities • Strengthening the accountability framework	1. Management systems, staffing and organisational development 2. Health and personal care 3. Resident lifestyle e.g. 3.8 cultural and spiritual life 4. Physical environment and safe systems

Attachment C: Links between the Cultural responsiveness framework and the HSCDP

Domain	Standards	HSCDP
Organisational effectiveness	1. A whole-of-organisation approach to cultural responsiveness is demonstrated	• Understanding clients and their needs • Partnerships with multicultural and ethno-specific agencies • A culturally diverse workforce • Using language services to best effect • Encouraging participation in decision making • Promoting the benefits of a multicultural Victoria
	2. Leadership for cultural responsiveness is demonstrated by the health service	• Understanding clients and their needs • A culturally diverse workforce • Promoting the benefits of a multicultural Victoria
Risk management	3. Accredited interpreters are provided to patients who require one	• Using language services to best effect • Understanding clients and their needs
Consumer participation	4. Inclusive practice in care planning is demonstrated including but not limited to: dietary; spiritual; family; attitudinal and other cultural practices	• Encouraging participation in decision making • Understanding clients and their needs
	5. CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis	• Encouraging participation in decision making • Understanding clients and their needs
Effective workforce	6. Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness	• A culturally diverse workforce • Understanding clients and their needs • Promoting the benefits of a multicultural Victoria

Attachment D: Cultural responsiveness planning template

Domain

Standard

	Gaps to be resolved	Actions/Strategies	Target outcome	Review date	Links to other CALD reporting frameworks, acceditation, etc.	Reporting period/Year
Measure						
Sub-measures						