

# FROM THE FIELD

## Cultural Competence And Health Care Disparities: Key Perspectives And Trends

Among stakeholders in managed care, government, and academe, cultural competence is emerging as an important strategy to address health care disparities.

by **Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo, and Elyse R. Park**

**ABSTRACT:** Cultural competence has gained attention as a potential strategy to improve quality and eliminate racial/ethnic disparities in health care. In 2002 we conducted interviews with experts in cultural competence from managed care, government, and academe to identify their perspectives on the field. We present our findings here and then identify recent trends in cultural competence focusing on health care policy, practice, and education. Our analysis reveals that many health care stakeholders are developing initiatives in cultural competence. Yet the motivations for advancing cultural competence and approaches taken vary depending on mission, goals, and sphere of influence.

CULTURAL COMPETENCE has gained attention from health care policy-makers, providers, insurers, and educators as a strategy to improve quality and eliminate racial/ethnic disparities in health care. The goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency. Bringing this to fruition requires action by various health care sectors, each with different motivations, approaches, and leverage points for advancing this field.

In 2002 we conducted interviews with ex-

perts in cultural competence from managed care, government, and academe to identify their perspectives on the subject. This paper summarizes key findings from this research and highlights recent trends in cultural competence in health care policy, practice, and education.

### ■ Emergence of cultural competence.

Cultural competence has emerged as an important issue for three practical reasons. First, as the United States becomes more diverse, clinicians will increasingly see patients with a broad range of perspectives regarding health, often influenced by their social or cultural backgrounds. For instance, patients may present their symptoms quite differently from the

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way they are presented in medical textbooks. They may have limited English proficiency, different thresholds for seeking care or expectations about their care, and unfamiliar beliefs that influence whether or not they adhere to providers' recommendations.<sup>1</sup>

Second, research has shown that provider-patient communication is linked to patient satisfaction, adherence to medical instructions, and health outcomes.<sup>2</sup> Thus, poorer health outcomes may result when sociocultural differences between patients and providers are not reconciled in the clinical encounter.<sup>3</sup> Ultimately, these barriers do not apply only to minority groups but may simply be more pronounced in these cases.<sup>4</sup> Finally, two landmark Institute of Medicine (IOM) reports—*Crossing the Quality Chasm* and *Unequal Treatment*—highlight the importance of patient-centered care and cultural competence in improving quality and eliminating racial/ethnic health care disparities.<sup>5</sup>

In our previous research we described three operational levels of cultural competence: organizational, systemic, and clinical.<sup>6</sup> These are the levels that guided our inquiry here.

■ **Perspectives from the field.** In 2002 we conducted interviews with thirty-seven experts in cultural competence from managed care, government (the U.S. Department of Health and Human Services, or HHS, and state and county departments of health), and academe (residency programs, medical schools, and professional organizations). Using a structured interview guide with ten open-ended questions, we asked these informants to identify important components of cultural competence on which action was possible; to describe leverage points for action and implementation; and to identify links to quality and the elimination of racial/ethnic disparities in health care.<sup>7</sup> Subjects were selected from lists of nationally recognized experts in cultural competence who had made presentations at one of a series of meetings, members of na-

tional expert advisory panels on cultural competence, and “snowball sampling” using sequential recommendations from initial key informants.<sup>8</sup>

Interviews were taped, transcribed, and coded by three independent researchers, who identified major themes according to frequency and relevance. The coding scheme was designed and overseen by a qualitative methods expert, and the final themes were reviewed by an expert in cultural competence.

Here we describe our findings and highlight recent trends in cultural competence since the completion of our research.

### Perspectives From Managed Care

■ **Cultural competence as a business and quality imperative.** Key informants viewed cultural competence

as being driven by both quality and business imperatives. Ideally, they felt that cultural competence might improve outcomes and help control costs by making care more effective and efficient. Although unaware of any direct evidence that supported this hypothesis, they acknowledged important circumstantial evidence. They also felt that health insurers could market cultural competence initiatives to employers as a method of expanding their member market share—especially given an increasingly diverse workforce.

■ **Leadership, systems, and education.** Key informants highlighted the “multilevel” nature of cultural competence, including diversity in leadership and in the health care provider network; systemic capacities, such as multilingual services and literature, data collection, and quality measurement (including patient satisfaction); and training for health care providers and staff. Many acknowledged resistance to training, given providers' perception of cultural competence as a “soft science.” As a method of achieving “buy-in,” they recommended that training be standardized and evidence based.

■ **Cultural competence links to quality**

**“Managed care can advance cultural competence by embedding these strategies into quality improvement initiatives.”**

**and addressing disparities.** Key informants felt that managed care can advance cultural competence by embedding these strategies into quality improvement initiatives. There was also unanimous sentiment that purchasers—with the appropriate information about how lack of culturally competent care contributes to disparities—can be instrumental in moving this issue forward. However, informants expressed skepticism given the multiple competing interests (including rising health care costs) purchasers face and their lack of knowledge about the issue. All informants made a link between cultural competence and eliminating racial/ethnic disparities in health care. However, they were reserved in their expectations of its potential impact in achieving this goal, given the many causes for disparities.

■ **Recent trends in managed care.** Recent trends in this industry bear out the key informants' perspectives on cultural competence. For example, health insurers, such as Kaiser Permanente, Aetna, and BlueCross BlueShield of Florida, have developed initiatives in cultural competence. Kaiser Permanente has had long-standing efforts that range from educational monographs in cultural competence to full-fledged "Centers of Excellence in Cultural Competence" targeting specific populations.<sup>9</sup> More than a year ago, Aetna began to collect race and ethnicity data on its members, developed culturally competent disease management programs, and mandated cultural competence training for its internal medical directors, nurses, and case managers.<sup>10</sup> BlueCross BlueShield of Florida has also embarked on initiatives that include internal diversity training and cultural competence education for providers.<sup>11</sup>

In addition, health care purchasing coalitions such as the National Business Group on Health have been active in informing their memberships about cultural competence and racial/ethnic disparities in health care.<sup>12</sup> Accreditation agencies, including the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), are also

exploring opportunities to include measures that track disparities and cultural competence.<sup>13</sup>

In sum, major advancements have occurred in the area of cultural competence among managed care plans, health insurers, and health care purchasers. However, there still exists strong resistance to investing in cultural competence as these entities search for evidence that supports a potential for quality improvement and cost savings. Organizations that have invested in cultural competence see themselves as being committed to issues of diversity, equity, and quality, and they acknowledge the potential for increasing market share through marketing of these efforts.

## Perspectives From Academe

■ **Training the future health care workforce.** Key informants from academe highlighted cultural competence as an educational strategy to prepare the future health care workforce to care for diverse patient populations. This group viewed cultural competence as the development of a skill set for more effective provider-patient communication. They stressed the importance of providers' understanding the relationship between cultural beliefs and behavior and developing skills to improve quality of care to diverse populations.

Several informants expressed concern about the persistence of stereotypic teaching strategies (such as treating Hispanics one way and African Americans another). They mentioned additional components that were underemphasized such as empathy, exploring socioeconomic issues, and addressing bias in the clinical encounter.

■ **Cultural competence education gaining momentum.** Key informants cited emerging regulatory/accreditation pressures for undergraduate and graduate medical education; societal pressures; funding opportunities; and increasing diversity of patients, students, and faculty as key drivers of cultural competence. However, a few stated that there is still progress to be made. Others expressed concerns that the present climate is fragile and potentially transient, threatening the sustainability

of the field.

■ **Better standardization and quality of educational programs.** Although informants felt that cross-cultural training efforts were well intentioned and helpful, they noted the need for a unified conceptual teaching framework. Many cited great variability in the availability and quality of training programs and also mentioned the education of faculty members as crucial, given their impact as clinical role models.

■ **Need for outcomes research.** Key informants highlighted greater attention to racial/ethnic disparities as a reason for cultural competence education. However, they worried that outcomes research on cultural competence interventions has been sparse. Nevertheless, most felt that cultural competence training could help reduce disparities.

■ **Recent trends in academe.** Since 2002 the regulatory pressures that informants highlighted have in fact become important drivers of curricular change. In response to the Liaison Committee on Medical Education's (LCME's) cultural competence accreditation standard, which requires all medical schools to integrate cultural competence into their curricula, the Association of American Medical Colleges (AAMC) has developed a "tool for the assessment of cultural competence training" (TACCT) to assist medical schools in the process.<sup>14</sup> At the 2004 AAMC annual meeting, several sessions highlighting TACCT were held to guide medical schools on how to meet their accreditation requirement in cultural competence.<sup>15</sup>

Similarly, residency programs have responded to the Accreditation Council of Graduate Medical Education's (ACGME's) cultural competence standards.<sup>16</sup> A 2004 paper in the *Journal of the American Medical Association* found that among close to 8,000 graduate medical educational programs surveyed in the United States, 50.7 percent offered cultural competence training in 2003–2004, up from 35.7 per-

cent in 2000–2001.<sup>17</sup> This was felt to be attributable to the recognition of the increasing diversity of the patient population, in response to pressure from ACGME and the IOM, which recommended that cross-cultural curricula be part of the training of clinicians from undergraduate to continuing medical education (CME).

The New York State Department of Health also made its mark in this area, as it modified its \$33 million per year Graduate Medical Education Reform Incentive Pool to reward residency programs that provide eight hours of cultural competence training to at least 80 percent of residents.<sup>18</sup> In the first year, 66 of the 104 residency programs in New York State proposed new cultural competence curricula.

Regarding CME, New Jersey has legislation pending that would require cultural competence education as a requirement for the licensure of health care professionals.<sup>19</sup> Professional societies, such as the American Medical Association and the American Nurses Association, have statements in support of, and are pursuing active agendas in, cultural competence education.<sup>20</sup>

In sum, academe has seen robust advances in cultural competence. Both the "stick" of accreditation and the "carrot" of incentives have been used to move the field forward.

## Perspectives From Government

■ **Increasing access to high-quality care for the most vulnerable.** Given the role of federal, state, and local governments in managing and financing health care delivery for vulnerable populations, cultural competence was seen as a method of increasing access to quality care for all patient populations. Key informants felt that minorities could have difficulty getting appropriate, timely, high-quality care because of linguistic and cultural barriers. As such, cultural competence aims to change a "one size fits all" health care system to one that is more responsive to the needs of

**"In academe, both the 'stick' of accreditation and the 'carrot' of incentives have been used to move the field forward."**

an increasingly diverse patient population.

■ **Key capacities of cultural competence.** Key informants highlighted essential components of culturally competent care, including diversity among staff and providers; system capacities, including data collection (to assess the needs of the patient population and track progress in improving health outcomes) and effective interpreter services; and cultural competence education for management, providers, and staff.

■ **Purchasing power as leverage to advance cultural competence.** Experts agreed that health care purchasers—both public and private—can help stimulate change if they understood the impact of disparities on cost and quality of health care and how cultural competence might address this problem. The roles of the Centers for Medicare and Medicaid Services (CMS), JCAHO, and state health care provider licensing boards were also mentioned, as was the need to clarify the “business model” for these interventions.

■ **Cultural competence as one step toward eliminating disparities.** Informants saw a clear link between cultural competence and eliminating racial/ethnic disparities in health care. However, there was agreement that disparities are the result of many factors and that cultural competence alone could not address the problem. The Culturally and Linguistically Appropriate Services (CLAS) standards project was often referred to as an effective blueprint for improving the cultural competence of our health care system.<sup>21</sup>

■ **Recent trends in government.** The federal government has been advancing the cultural competence agenda in various ways. For instance, the Health Resources and Services Administration (HRSA), in partnership with the Institute for Healthcare Improvement (IHI), has developed Health Disparity Collaboratives focused on addressing racial/ethnic disparities at community health centers.<sup>22</sup> Through the use of quality improvement models, several strategies are being implemented to improve health care delivery to diverse populations, including developing culturally competent systems of care and techniques for more

effective cross-cultural communication. The National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) have funded research and education in cultural competence over the past few years.<sup>23</sup>

On the federal legislative side, there has been less progress. In 2004 several bills were developed in the House and Senate targeting the elimination of racial/ethnic disparities in health care.<sup>24</sup> Within this proposed legislation have been activities related to cultural competence education. Although none of these were brought forward for a vote, they may still move forward in the upcoming years. Most notably, it appears that cultural competence has caught the attention of federal policymakers as part of the effort to eliminate racial/ethnic disparities.

AMONG THESE PERSPECTIVES from managed care, government, and academia, there was a strong sense that the field of cultural competence in health care is emerging and that organizational, systemic, and clinical facets are central to its advancement. The informants described a clear link between cultural competence, improving quality, and eliminating racial and ethnic disparities in health care. National trends confirm this viewpoint, as many major stakeholders have responded by supporting efforts in cultural competence. Yet the motivations for advancing the issue of cultural competence—and the approaches different stakeholders are taking—vary depending on mission, goals, and sphere of influence. Despite these differences, many synergies exist that should allow for the continuing development of cultural competence in health care. Indeed, cultural competence seems to be evolving from a marginal to a mainstream health care policy issue and as a potential strategy to improve quality and address disparities.

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 The authors thank Owusu Ananeh-Firempong for his assistance in this research, all of the key informants who graciously gave of their time to provide their perspectives, and Angela Maina for her assistance in preparing the manuscript. This research was supported by a grant from the Commonwealth Fund entitled "Cultural Competence in Health Care." The views presented here are those of the authors and should not be attributed to the Commonwealth Fund, its directors, officers, or staff.

#### NOTES

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