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Culturally Competent
Health Care

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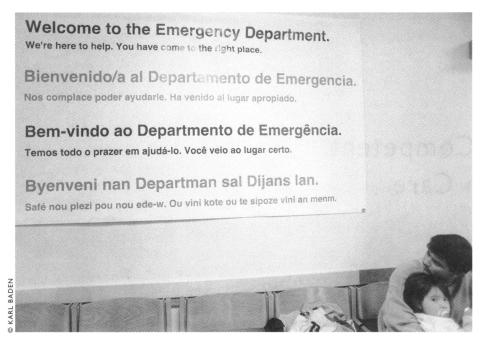
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WITH THE GROWING DIVERSITY OF THE US POPULATION, MEMBERS OF minority "racial"/ethnic groups have sought to eliminate the adverse effects of racism on the delivery of health care services. Demands for culturally competent health and mental health services grew out of the failure of service delivery systems to be responsive to all segments of the population. The importance of *cultural sensitivity* was initially emphasized in providing services to members of ethnic minority groups, especially given the language and cultural barriers faced by non-English-speaking immigrants and the racial and economic barriers faced by people of color. Despite a call for responsiveness to cultural differences in attitudes, behaviors, beliefs, values, and lifestyles as well as language, mainstream health and mental health care systems continued to fail for these underserved groups. In the 1960s, the community health and mental health movements dovetailed with the Civil Rights Movement, giving voice to the dilemmas of agencies and communities grappling with the availability of services to ethnic minority groups and low-income populations.

During the 1980s, the focus shifted from cultural sensitivity to a demand for cultural competence, a skill-focused paradigm. While the use of bilingual/bicultural providers and the importance of knowing the culture of one's clients continued to be stressed, this transformation to a skill focus resulted in efforts to operationalize those components necessary to achieving cultural competence at the system level.

With the growth of managed care and other changes in the organization of health care during the 1990s, advocates of cultural competence began to express a concern that the small gains made by institutions and agencies in the previous decade could be lost. In an environment of cost containment, many fear that cultural competence as a priority will be subordinated to economic and market incentives.

WHAT IS CULTURAL COMPETENCE?

The pivotal 1989 monograph, *Toward a Culturally Competent System of Care,* defined cultural competence as a set of behaviors, attitudes, and

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Welcome to the Emergency Department.
We're here to help. You have come to the right place.

Bienvenido/a al Departamento de Emergencia.
Nos complace poder ayudarle. Ha venido al lugar apropiado.

Bem-vindo ao Departmento de Emergência.
Temos todo o prazer em ajudá-lo. Você veio ao lugar certo.

Byenveni nan Departman sal Dijans lan.
Saté nou plezi pou nou ede-w. Ou vini kote ou te sipoze vini an menm.

policies that enable a system, agency, or group of professionals to work effectively in cross-cultural situations.[1] "A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to culturally unique needs."[1]

Many definitions have since emerged, often focused on the process necessary to achieve cultural competence or the criteria to decide whether it has been achieved.[2-9] The California Cultural Competency Task Force, established in 1994 by the state's Department of Mental Health, defined "cultural competency" as "appropriate and effective communication which requires the willingness to listen to and learn from members of diverse cultures, and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of an individual's cultural health beliefs and practices."[10]

CULTURALLY COMPETENT HEALTH CARE

The rapid growth of managed care, increased privatization of services, and increased competition within the tertiary care system provided the impetus for rapid change in the health care environment. This resulted in increasing integration of services—between primary and tertiary care, and between hospitals and community-based systems.

Health and mental health systems, which have histor-

ically been separate, are also being integrated in response to these trends. A growing recognition of psychosocial influences on lifestyle behaviors, patient compliance, and disease management, along with evidence that the onset and course of chronic conditions can be modified by lifestyle behaviors, have resulted in increased emphasis on prevention and patient education. The contribution of sociocultural factors to lifestyle behaviors and "racial"/ethnic differences in health beliefs, lifestyle behaviors, and health behaviors make this an issue of cultural competence.

Many institutions now articulate a commitment to cultural competence, have cultural competence initiatives, or have offices designated to address specific needs of ethnic minority populations. It is increasingly common for organizations to state a commitment to diversity, multiculturalism, or cultural competence in their goals, objectives, or mission statements.

As advocacy groups challenge the system to serve diverse segments of the population, and as ethnic minorities grow in market share, there is economic value in marketing to a diverse population. Harvard Medical School and Beth Israel Deaconess Medical Center in Boston have made the case for cultural competence as good business sense.[11] Diversity and cultural competence have become buzzwords for maintaining a competitive edge while satisfying affirmative action objectives.

Providers, hospitals, and payers are beginning to realize the economic value of catering to diverse populations in order to capture market share. Mainstream institutions are increasingly partnering with community-based organizations to gain access to minority consumers; these partnerships are attractive because they pair the resources of large institutions with access to minority consumers. At the same time, the growing dominance of megaproviders has threatened the viability of small community-based organizations that have historically targeted specific ethnic communities.

Cultural competence has a very different meaning for organizations dedicated to serving culturally specific populations than for those dedicated to serving all populations. While cultural competence is core to the missions

RECOMMENDED STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES[19,20]

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training, and, as appropriate, treatment planning.
4. Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.
5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.
6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
8. Translate and make available signage and com-

monly-used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.
10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.
11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.
12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for [culturally and linguistically appropriate services (CLAS)] into other organizational internal audits and performance improvement programs.
13. Develop structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive. or discriminatory treatment, or difficulty in accessing services, or denial of services.
14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

and programs of ethnic-specific organizations, their goal is not to be diverse but to fill unmet needs and advocate for the larger system to be more responsive to their targeted populations. In contrast, to be culturally competent, mainstream organizations need to be responsive to all segments of the population.

The Office of Minority Health of the US Department of Health and Human Services (DHHS) has developed draft standards for culturally and linguistically appropriate health care services (see box on page 27), which have been made available through DiversityR$_x$, a website sponsored by the National Conference of State Legislatures,

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Resources for Cross Cultural Health Care, and the Henry J. Kaiser Family Foundation. These standards emphasize that "culture and language have considerable impact on how patients access and respond to health care practices" and that the provision of culturally and linguistically appropriate health care services "has the potential to improve patient outcomes and the efficiency and cost-effectiveness of health care delivery."[12] The following example illustrates this point.

> [A]n elderly Bosnian woman being admitted with terminal cancer may present the following challenges for health care staff and organizations: she and her family do not read, speak or understand English; her Muslim faith requires modesty during physical examinations; and her family may have cultural reasons for not discussing end-of-life concerns or her impending death. A culturally and linguistically appropriate response would include interpreter staff; translated written materials; sensitive discussions about treatment consent and advance directive forms; clinical and support staff who know to ask about and negotiate cultural issues; appropriate food choices; and other measures.[12]

CULTURAL COMPETENCE AT THE SYSTEM LEVEL

The prevalence of negative stereotypes about Black and Hispanic groups as well as the view of Asian Americans as the "healthy model minority" have resulted in discriminatory practices in health care service delivery and resource allocation. It is clear that the sociopolitical contexts of poverty, racism, immigration, and culture have had a significant bearing on access to health care, utilization of services, and health status and for all "racial"/ethnic groups. Yet, discussions of cultural competence in health care have generally been limited to the issue of language access and the ability of providers to speak with patients in their primary language. The

focus of cultural competence initiatives has been on the provider-patient relationship with little attention given to whether the systems of care in which they function are culturally competent. Moreover, cultural competence has yet to be made integral to health professions training or essential to standards of professional practice.

To ensure that a system of care is culturally competent, one might ask: Do all segments of the population have equal access to care? What are the utilization patterns for different "racial"/ethnic groups? Is quality care provided, as measured by the health status of designated population groups?

Access to care. Access to care, or the degree to which services are convenient and quickly and readily obtainable, is a cultural competence issue. Cultural and linguistic barriers have been a primary focus of advocates of culturally competent care. For non-English-speaking populations, the paucity of bilingual providers has necessitated interpreters as intermediaries in the provider-patient dyad. While few have argued the importance of being able to communicate with the patient in his/her primary language, controversy has arisen over the implementation and cost of interpreter services.

Ethnic-specific agencies and community-based organizations are likely to employ both bilingual providers and support staff—such as nursing assistants, case managers, or outreach workers—who perform patient-related functions in addition to serving as interpreters. Hospitals often use interpreter pools, with AT&T interpreters commonly used as back-up, or for less common dialects or languages. The use of AT&T interpreters has been criticized because the interaction is not face-to-face and often involves untrained interpreters or ones who are unfamiliar with medical terminology. The use of interpreters, in general, has been criticized because relying on interpreters often entails longer waits, inappropriate translations, and inconvenience in scheduling appointments. On the other hand,

the lack of interpreters and the reliance on family members, especially young children, have also been criticized.

While generally considered necessary to ensure access to care, the cost of interpreters is not factored into reimbursement mechanisms. Nor are differential reimbursement or incentives factored in for bilingual providers. Some agencies and institutions offer higher pay scales for bilingual providers as a recruitment incentive. While this is a positive development, it has inadvertently resulted in large institutions competing for staff with higher salary differentials that can not be matched by ethnic-specific agencies.

Cultural barriers to access, while recognized as important to cultural competence, are often given little attention in the implementation of programs and policies within a system. Some institutions have attempted to provide not only translated materials but also culturally relevant and appropriate materials for use in marketing and outreach efforts.

Population-based vs geographic boundaries. The growth of megaproviders and the development of regional networks have consistently defined access to care based on geographic boundaries rather than community- and population-based criteria. This geographic focus in parceling out covered lives to managed care systems and in identifying vendors from which to purchase services fails to take into account the fact that distinct ethnic communities may cross geographic boundaries. When defined from a geographic focus, specific ethnic populations become more costly to serve and cultural competence becomes an add-on cost.

Utilization. Utilization refers to which services are being used, their availability in a system, how frequently they are used, and whether their use is appropriate. Utilization patterns have been shown to differ across population groups. Low-income immigrants and refugees from ethnic minority groups typically delay entry into care, underutilize services, and/or overutilize emergency room services because of language, cultural, and financial barriers.

Enabling services—case management, outreach, transportation, and babysitting services, among others—have typically been found necessary to promote appropriate utilization on the part of low-income and ethnic minority populations. While many ethnic-specific agencies offer these services, few cost-benefit analyses by population groups of these strategies have been conducted. Nor has such data been used to target resource

allocation and program development. These services are not covered by most reimbursement mechanisms; if provided, they are usually funded through grants. One solution to recognizing and reimbursing enabling services has been to include an approximately $1.50 adjustment in the per member per month capitation rate to cover the cost of these services, as has been the case in California and Hawaii.

Quality of care. While the demand for culturally competent care has focused on the ability to access and utilize care, cultural competence is increasingly being seen as important to quality of care.[13–15] Quality indicators must incorporate principles and measures of cultural competence focusing on the policies, procedures, and resources needed to provide linguistically appropriate and culturally relevant services at all points of client contact within a system.

Health care organizations typically presume they are color blind in their delivery of services. Few providers have thought about the biases they bring to patient encounters or about their own cultural/ethnic backgrounds, health beliefs, and health practices. These biases often result in both the system and its providers attempting to get the patient to conform to the mainstream instead of meeting a patient on her or his own cultural ground. Yet patient attitudes about health, religious views, and concepts of death often influence compliance, affect disease management, and alter health outcomes. Views of race and power also influence the nature of the communication between clinician and patient.

Religious beliefs, concepts of health, and health practices that are uncommon in Western medicine potentially raise ethical dilemmas and risk management issues if unfamiliar to a system or its providers.

Consider the following scenarios.[16]

A physician prescribes medication without knowing about the patient's use of an herbal medicine that has adverse interaction effects.

A Cambodian refugee uses *cao gio*, or coin rubbing, to dispel the "bad wind" and restore the natural balance between hot and cold elements of the universe when her daughter is feverish. The bruise left by this remedy is reported as a sign of abuse by the provider.

While the availability and use of interpreters is a basic and necessary criterion to ensure quality of care when providers do not speak the language of the client, it is not

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sufficient. The definition of a culturally competent system of care must go beyond interpreter support to the use of bilingual providers and the provision of culturally appropriate care.

CULTURAL COMPETENCE IN A MANAGED CARE ENVIRONMENT

As the service delivery system has shifted toward a managed care model, there has been a growing concern that cost-containment efforts will marginalize the demand for cultural competence as something "nice" to do but too expensive to implement. In fact, it is more costly for systems to add on a patchwork of services inappropriate to population needs and cost-effective for population-specific services to be integrated into the fabric of care.

The development of provider networks and megaproviders to offer a continuum and comprehensive array of services has resulted in a contracting process that favors these networks and adversely selects against small community-based providers.

Few demands have been made of managed care organizations to be more responsive to diverse groups in their policies and procedures. Questions to be addressed include:

- What benefits are covered in the plan? Are they specific and relevant to diverse populations? For example, is coverage provided for alternative medical treatments that are commonly used by members of ethnic minority groups?
- What about access? Does the gatekeeper function, a keystone of managed care, prevent access to care for those most in need?
- Who is eligible? How does one get into the plan? Is there adverse selection against ethnic minority populations because they are seen as high risk?
- What about the provider network? Does limiting the number of providers in a panel result in limiting access to bilingual/bicultural providers? How are

providers evaluated as to their level of cultural competence?
- How is patient satisfaction measured? Are surveys conducted only in English?
- Given the tendency among ethnic minority groups to underutilize services, what outreach efforts are made to promote access and utilization by these groups?
- As managed care organizations develop criteria and guidelines to manage provider networks, what consumer protections exist to ensure that they do not inadvertently pose barriers for different "racial"/ethnic groups.

Consumer protections are needed to ensure that profiling and risk adjustment ratings are not used by managed care organizations to adversely impact ethnic minority populations. Utilization reviewers could deny authorization for services based on set criteria that fail to take into account different cultural practices or preferences. While managed care organizations are increasingly emphasizing a consumer-oriented approach, quality indicators and consumer satisfaction ratings often fail to include criteria for cultural competence, which are deemed secondary in importance to cost considerations. For example, member satisfaction surveys are generally conducted only in English, even when plans have significant percentages of non-English-speaking members. Quality measures are not specific to the health outcomes of diverse populations. Providers are not identified by ethnicity to allow consumer choice. Measures of cultural competence are absent from the extensive credentialing process required of providers in the network. Reimbursement for interpreter services is considered a cost to be borne by individual providers.

PROFESSIONAL GUIDELINES AND REGULATORY STANDARDS

Recently, there has been a proliferation of initiatives calling for cultural competence within scopes of practice. Many

institutions are playing catch-up by offering workshops, courses, conferences, and other continuing education programs to train their providers. Often, this takes the form of providing information about specific populations and communities under the premise that one must know about the beliefs, values, practices, and lifestyles of a particular culture in order to work with people from that culture. While knowledge of a culture is important, there is a danger of reinforcing stereotypes and discriminatory practices when providers gain only a superficial grasp of cultures or continue to view issues from their own perspectives.

Standards and guidelines, when they exist, often define cultural competence as a goal. But there has been little translation of these goals into quality indicators or outcomes that can be measured, monitored, evaluated, or mandated.

Existing guidelines and standards have been limited to language access or interpreter support, for example, P.L. 101-527, the Disadvantaged Minority Health Act of 1990. Despite limited funding, this legislative directive was important because it spawned the growth of related initiatives. The Center for Linguistic and Cultural Competence in Health Care was established in 1995 by the DHHS Office of Minority Health to address the health needs of limited-English-speaking populations. P.L. 101-527 also resulted in an expansion of the Civil Rights Act of 1964 to include inadequate interpretation as a form of discrimination; cultural competence was now defined as a civil rights issue.

In 1996, the Society of Teachers of Family Medicine (STFM) published curriculum guidelines for teaching culturally sensitive and culturally competent health care to family medicine residents and other health professions students.[17] The Health of the Public Initiative, funded by the Pew and Rockefeller Foundations, used a systemic approach to promote the health of communities and to reorient academic medical centers toward community health needs.[18]

The federal Health Care Financing Administration issued a draft regulation in September 1998 to require state agencies to ensure that managed care organizations provide services to Medicaid beneficiaries in a culturally competent manner.

Based on a review of laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, the DHHS Office of Minority Health has developed draft national standards for culturally and linguistically appropriate health care services with input from a national advisory committee of policy makers, providers, and researchers (see box on p. 27).[19, 20]

MEASURING OUTCOMES

We are now seeing an emphasis in health care on quality indicators and measurable outcomes. While the development of professional standards has implications for licensure and accreditation, the measurement of outcomes has implications for reimbursement and accountability. The identification of quality indicators provides the clinical and program criteria against which to measure these outcomes. The Bureau of Primary Health Care of the US Health Resources and Services Administration has identified seven such indicators specific to cultural competence.[21]

Cultural competence initiatives in several states have resulted in the development of some assessment tools to measure outcomes.[22-24] These assessment tools are mostly process and survey tools and include patient satisfaction surveys, provider self-assessment questionnaires, and organizational self-assessment checklists.

"Report cards" that operationalize, measure, and monitor quality indicators to hold health care providers and payers accountable are also being considered as a tool to assess cultural competence. Cultural competence guidelines developed by the Center for Mental Health Services in conjunction with the Western Interstate Commission for Higher Education have come closest to identifying indicators against which to measure access, utilization, and quality.

Currently, the Joint Commission on Accreditation of Health Care Organizations, which regulates hospitals, and the National Committee on Quality Assurance, which developed Health Plan Employer Data and Information Set (HEDIS) measures to evaluate health plan performance, have a quality indicator related to cultural competence that is limited to language access. It measures the number of bilingual/multilingual providers and staff available but has not addressed the complexities of language access or cultural appropriateness.

Several existing quality improvement tools (QI) have the potential to incorporate dimensions of cultural competence and can be used to define and track outcomes of interest for populations at risk. The Agency for Health Care Policy and Research (AHCPR) has developed CONQUEST, a QI software tool comprised of clinical performance measures related to provider behavior (for example, whether appropriate action was provided at the right time) and clinical procedures. AHCPR's Healthcare Cost and Utilization Project Quality Indicators (HCUP QIs), a set of 33 clinical performance measures addresses adverse hospital outcomes, inappropriate utilization, and avoidable hospital admissions.

Other assessment tools have focused on expenditures or utilization patterns. The Medical Expenditure Panel Survey (MEPS) reports on a nationally representative subsample of the National Health Inventory Survey (NHIS) sample; both surveys are conducted by the National Center for Health Statistics (NCHS). While neither of these tools was developed to measure cultural competence, MEPS does disaggregate use and expenditure by "racial"/ethnic groups and can potentially be used to identify "racial"/ethnic variations in utilization patterns.

MONITORING DISPARITIES

While the emphasis on outcomes has a bearing on scopes of practice, it is important that these outcomes be tied to the health status of specific population groups. Yet most outcome measures presume uniformity across the population.

The 1985 Report of the DHHS Secretary's Task Force on Black and Minority Health[25] highlighted racial disparities in health. While this report on racial disparities has been effective in drawing national and local attention to improving the health status of black and Hispanic Americans, it has been challenged for ignoring significant and meaningful disparities among other ethnic minority groups. Asian American and Native American groups, in particular, have criticized its inadequacies in masking significant differences among the "racial"/ethnic groups that make up a disproportionately smaller share of the population. The failure to identify and adequately sample relevant health status indicators resulted in few of the Healthy People 2000 objectives targeting these groups.[26] The public health datasets upon which this report is based have also been challenged because of their failure to disaggregate "racial"/ethnic groups, insufficient sample sizes to make for meaningful analyses,[27] inadequate sampling methods, and selection bias in failing to identify diseases relevant and specific to ethnic minority populations.

Many researchers in ethnic minority communities now support the use of a resiliency approach, or the identification of protective factors, as an alternative to validate and promote those elements that are positive and facilitative to survival and adaptation within a "racial"/ethnic group.[28]

Use of ethnic identifiers. An underlying notion of a culturally competent system of care is that it is responsive to each of the diverse groups within the total population. To achieve cultural competence within the health care system, we need to start from a premise that all segments of the population should have equal access to quality care. To do this, we need to look at population demographics—who makes up the population, who is or is not served. The ability to identify the ethnicity of consumers is critical.

As the population becomes increasingly diverse, it becomes increasingly clear that a uniform standard based on the white population can no longer be the norm for public health indicators. Data need to be disaggregated for meaningful analysis and competent health planning. The US Census has increased the number of "racial"/ethnic classifications for the 2000 Census and will allow for multiracial classifications for the first time. In general however, "racial"/ethnic data, if available, tend to be collected only for white, Hispanic, and black populations. Native Americans and Asian Americans are generally excluded. Data are not collected separately for significant subgroups within "racial"/ethnic populations, yet the ability to capture subgroup differences is essential. With more than 20 identified ethnic groups among the Asian and Hispanic American populations and 365 recognized Native American tribes, significant within-group differences might be masked by aggregating data.

The measurement of access to care, service utilization, quality of care, and health status has been critical to identifying the health of the nation's population and its communities. The use of "racial"/ethnic identifiers and the ability to distinguish differences across communities enables policy makers, payers, and service providers to target interventions to specific population needs. At the same time, consumer protections are essential to avoid any adverse effects of identifying ethnicity. For example, ethnic identifiers could be used for profiling high risk and frequent users for adverse risk selection. ·

CONCLUSION

This is a new age of economic imperatives. As we enter the 21st century, the health care system is evolving toward an integrated system combining hospital and community systems, health and mental health services, Western and traditional medicine, primary and tertiary care, technology and clinical practice, and so on. As providers and system strive to gain market share, competition for patients and covered lives increases. Regional systems, alliances, mergers, and networks have become common, with megaproviders dominating the marketplace.

Advocacy for culturally competent health care grew from the ranks of community-based organizations targeting ethnic-specific populations. It is essential that these providers do not become defunct as the health care system evolves.

While awareness of culture and the imperative of cultural competence has grown significantly over the past decades, there is still much to be done. Mission statements, goals, and objectives need to be translated into action plans. Programs, services, and all levels of the system, including payers and regulatory authorities, need to be evaluated and audited as to their level of cultural competence. And standards of culturally competent care need to be developed, mandated, and monitored across these multiple sectors for the health care system to be responsive to all segments of the population.

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