



**IMPROVING QUALITY AND ACHIEVING EQUITY:  
THE ROLE OF CULTURAL COMPETENCE IN REDUCING  
RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE**

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**ABSTRACT:** This report reviews key principles of quality (as it relates to the overall quality of the health care system and individual approaches to quality improvement); reviews evidence of the existence and root causes of racial and ethnic health disparities and recommendations to address them; and discusses strategies by which the quality and cultural competence movements could be linked. In particular, it focuses on the Institute of Medicine's six principles for designing a high-quality health care system to identify areas where aspects of cultural competence would be central to achieving high quality. It then presents a framework outlining both hypothetical and proven strategies for delivering high-quality, culturally competent care.

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## CONTENTS

About the Author .....	iv
Acknowledgments .....	iv
Executive Summary .....	v
Introduction .....	1
Key Principles in Quality: Where Are We Today?.....	2
General Health Care System Quality .....	2
Racial/Ethnic Disparities in Health Care: What Do We Know? .....	3
Improving Quality to Address Disparities .....	4
Defining Cultural Competence .....	4
Addressing General Health Care System Quality .....	5
Addressing Specific Quality Improvement Initiatives .....	10
Quality, Cultural Competence, and Disparities: Hypotheses Versus Evidence .....	12
Conclusion .....	15
Notes.....	16

## LIST OF TABLES

Table ES-1 Health System Level Factors, Care-Process Variables, and Patient-Level Variables .....	viii
Table 1 Health System Level Factors.....	13
Table 2 Care-Process Variables .....	14
Table 3 Patient-Level Variables.....	14

## ABOUT THE AUTHOR

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## EXECUTIVE SUMMARY

The 2001 Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, highlights a significant gap between the quality of health care people should receive, and the quality of care they actually receive. But it is important to consider more than just provision of recommended care in determining health care quality. There is growing recognition that—in addition to being based on the best available scientific evidence—health care should also be easy to navigate, safe, accessible, and responsive to patients’ needs. Countless studies, culminating in another influential IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), have found that people of color often receive a lower quality of care than their white counterparts—even when insurance and socioeconomic status, comorbidities, stage of presentation, and other factors are taken into account.

This report identifies aspects of cultural competence that are synergistic with current efforts to develop a system that delivers higher-quality care and discusses strategies by which the quality and cultural competence movements could be linked.

### **Cultural Competence and Health Care Quality**

To understand how cultural competence ties into efforts to address disparities and improve general health care system quality, it is helpful to carefully examine the six IOM principles of quality.

**Safety:** According to the IOM, patient safety is not solely about addressing general systems issues to prevent the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim (such as administering the wrong medication or dosage). It also entails: avoiding misdiagnosis, preventing patients from exposure to unnecessary risks; and ensuring informed consent. *Unequal Treatment* highlighted the importance of improving provider–patient communication as a method of addressing racial/ethnic disparities in health care. In particular, the report recommended that health care providers be trained in cross-cultural communication and that health care systems support the use of interpreter services for patients with limited English proficiency. Improved communication through such means has the potential to: improve the capacity of health care providers to make accurate diagnoses; prevent patients from exposure to unnecessary risks from diagnostic procedures (particularly where language barriers play a role); enable providers to obtain truly informed consent; and allow patients to participate in clinical decision-making.

*Effectiveness.* *Crossing the Quality Chasm* highlights the importance of using evidence-based guidelines to provide high-quality care. It defines “evidence-based practice” as the integration of the best research evidence with clinical expertise and patient values. Two aspects of cultural competence—systemic and clinical—can play a role in improving effectiveness. First, in order to ensure effective care, systems must be in place to detect health disparities by stratifying measures by race/ethnicity. Use of interpreter services as a vehicle for improving communication is also essential. Second, clinical cultural competence, which includes health care providers’ ability to ascertain patient preferences and values, is a clear component of effectiveness.

*Patient-centeredness.* *Crossing the Quality Chasm* states that compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient are the hallmarks of patient-centeredness. Many would agree that these attitudes and skills are also central to clinical cultural competence.

*Timeliness and efficiency.* *Crossing the Quality Chasm* states that a timely system is one that prevents patients from experiencing harmful delays in receipt of necessary services, and that an efficient system is one that avoids quality and administrative waste. Language barriers may contribute to increased length of stay in the hospital or longer wait times in an emergency department. Systemic cultural competence could thus improve the timeliness and efficiency of a system by getting patients the services that are appropriate in an expeditious fashion.

*Equity.* *Crossing the Quality Chasm* states that a system is high quality if it provides care that does not vary because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. Systemic cultural competence, which entails processes to monitor the quality of care and detect disparities by stratifying measures by race/ethnicity, would lay the foundation for targeted quality improvement activities.

### **Quality Improvement Approaches**

Specific quality improvement approaches, such as disease management (DM) and the chronic care model (CCM), have typically operated in “cookie-cutter” fashion, relying on technology, telephone contacts, and case management. A review of the key principles of CCM and DM identifies areas where cultural competence could be embedded.

- *Identify patients who need care:* Since both the CCM and DM create registries of patients with specific chronic conditions (e.g., diabetes), a culturally competent approach would ensure that these registries are stratified by race, ethnicity, and

language proficiency and thus geared to identify racial/ethnic disparities in health care.

- ***Provide care by tailoring the methods used to the patient's needs:*** In CCM and DM programs, physicians, case management nurses, and other members of multidisciplinary care teams seek to communicate with patients outside of the traditional office visit, for example through telephone contact, e-mail, and group visits. A culturally competent approach would establish ways to communicate with patients with limited English proficiency, limited health literacy, alternative health beliefs, and other needs.
- ***Support physicians and multidisciplinary teams in their clinical decision-making:*** Once sociocultural barriers to care are identified and interventions to address them are put in place, physicians could be enlisted to help. For example, physicians could be provided with information solicited by other health care team members regarding patients' understanding of their conditions or their fears and concerns about a medication. Thus, physicians' clinical decision-making and care management strategies could be informed by information about patients' sociocultural barriers to care and can engage in culturally competent approaches to address them.
- ***Support patients in their ability to help manage their own illnesses:*** To make this process culturally competent, educational information could be provided to patients in the appropriate languages and reading levels. In addition, self-management advice and strategies should take into account key issues related to patients' social context, such as their physical environment and ability to exercise.
- ***Provide physicians, teams, and physician organizations with feedback on their performance:*** Stratifying performance feedback by race, ethnicity, culture, and language proficiency would enable health teams to identify issues as they arise, and address them as they emerge in distinct populations.

### **Quality, Cultural Competence, and Disparities: A Framework**

This analysis presents a framework to consider the interplay among cultural competence, quality, and racial/ethnic disparities in health care. It presents hypothetical interventions based on evidence, as well as evidence of strategies that have been found to work. The framework, presented in Table ES-1, explores the root causes of disparities, how cultural competence might address them, and what other approaches outside of cultural competence are needed. Any efforts to address racial/ethnic disparities must be predicated on effective, standardized collection of race/ethnicity data, stratification of those data by race/ethnicity, and commitment to developing interventions to address disparities if and when they are found.

Table ES-1. Health System Level Factors, Care Process Variables, and Patient-Level Variables

<b>Root Cause of Disparities</b>	<b>Cultural Competence Strategies to Address Them</b>	<b>Other Strategies to Address Them</b>
<b>Health system level factors</b>		
Health system complexity (system particularly complex for those with limited English proficiency, low health literacy, mistrust, and little familiarity with the Western model of health care delivery and practice)	Multilingual signage <sup>H</sup> Interpreters <sup>E</sup> Multilingual, low literacy written materials <sup>H</sup> Culturally competent disease management <sup>E</sup> Health care navigators <sup>E</sup>	General disease management <sup>E</sup>
<b>Care process variables</b>		
Little attention or skill in dealing with patients from diverse sociocultural backgrounds leading to poor communication and clinical uncertainty	Cultural competence education <sup>H</sup>	
Provider stereotyping of patients leading to different recommendations for diagnostic or therapeutic procedures	Curricula on the impact of race/ethnicity on clinical decision-making <sup>H</sup>	Physician reminders (e.g., via electronic medical records) <sup>E</sup> Performance review, reporting, and detailing <sup>E</sup>
Providers caring for patients with limited-English proficiency in the absence of an interpreter	Interpreters <sup>E</sup>	
<b>Patient-level variables</b>		
Difficulty navigating the health care system	Health care navigators <sup>E</sup>	Patient reminders <sup>E</sup>
Mistrust and discomfort voicing concerns or asking questions of the provider	Patient activation programs <sup>H</sup>	

Note: H=Hypotheses, E=Evidence.

Source: Author's analysis.

# **IMPROVING QUALITY AND ACHIEVING EQUITY: THE ROLE OF CULTURAL COMPETENCE IN REDUCING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE**

## **INTRODUCTION**

The 2001 Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, highlights a significant gap between the quality of health care people should receive, and the quality of care they actually receive.<sup>1</sup> The largest and best-designed national study done to date on this issue found that, for 439 indicators of quality, covering preventive care as well as acute and chronic medical conditions, patients received recommended care only 55 percent of the time.<sup>2</sup> A follow-up study conducted among this population showed that although racial and ethnic disparities were less evident in basic primary care measures, they exist in many tertiary care measures.<sup>3</sup>

But it is important to consider more than just provision of recommended care in determining health care quality. There is growing recognition that—in addition to being based on the best available scientific evidence—health care should be easy to navigate, safe, accessible, and responsive to patients’ needs.<sup>4</sup>

Perhaps for no one group is the issue of quality improvement more pressing than for people of color in the United States. Countless studies, culminating in another influential IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), have found that people of color often receive a lower quality of care than their white counterparts—even when insurance and socioeconomic status, comorbidities, stage of presentation, and other factors are taken into account.<sup>5</sup> Such health disparities have garnered attention from key health care stakeholders, who see them as evidence of inequality in quality.<sup>6</sup>

*Unequal Treatment* provides recommendations that are regarded as a blueprint for eliminating racial/ethnic disparities in health care. Several of these focus on making our health care system and its workforce better equipped to address disparities by becoming “culturally competent” and responsive to the needs of diverse patient populations. Whereas some recommendations target the health care system generally, several focus on improving quality of care by advancing from a “one-size-fits-all” approach to an approach that is more culturally competent and tailors care to the preferences and needs of individual patients and patient groups in its goals, design, and methodology.

Previous studies have sought to identify the link between cultural competence and elimination of racial/ethnic disparities in health care.<sup>7</sup> This report identifies aspects of cultural competence that are synergistic with current efforts to develop a system that delivers higher-quality care. The ultimate goal is to identify how cultural competence links to quality, and in turn how efforts to make health care more culturally competent may be tied-in to efforts to eliminate racial and ethnic disparities in health care. To accomplish this goal, this report:

- reviews key principles of quality (as it relates to the overall quality of the health care system and individual approaches to quality improvement);
- reviews evidence of the existence and root causes of racial and ethnic health disparities and recommendations to address them; and
- discusses strategies by which the quality and cultural competence movements could be linked.

### **KEY PRINCIPLES IN QUALITY: WHERE ARE WE TODAY?**

Quality has been defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”<sup>8</sup> Over the past 25 years, there has been growing interest in determining how the quality of health care can be improved. Beginning with basic issues of measurement—including Donabedian’s system of structure, process, and outcomes—and evolving to methods for accreditation and now pay-for-performance, the quality movement has been in constant flux.<sup>9</sup>

### **General Health Care System Quality**

*Crossing the Quality Chasm* highlights the fact that quality is a system property, and that our current system of health care delivery is in need of redesign. Thus, tinkering with the current system, or asking health care professionals to work harder or do things somewhat differently, will not achieve this goal. As such, the IOM report recommends that the health care system be restructured and monitored based on the following six principles:

1. **Safety:** Patients should not be harmed by the care that is intended to help them, and they should remain free from accidental injury. Ensuring patient safety requires that patients be informed about and participate in their care as much as they wish and are able. Patients and their families should not be excluded from learning about uncertainty, risks, and treatment choices. The report states: “an informed patient is a safe patient.”

2. **Effectiveness:** Patients should receive care that is based on the use of evidence that determines whether an intervention (e.g., a preventive service or a diagnostic test) produces better outcomes.
3. **Patient-Centeredness:** This principle encompasses the qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient. This includes the patient's ability to participate in decision-making, obtain the information they need, be heard, and participate in systems of care that are responsive to their needs.
4. **Timeliness:** Patients should not experience harmful delays in receiving necessary services, and waiting times should constantly be reduced.
5. **Efficiency:** Systems should use resources to get the best value for the money spent. This can be achieved by reducing waste as well as administrative and/or production costs.
6. **Equity:** Systems should provide care that does not vary in quality because of characteristics such as gender, ethnicity, geographic location, and socioeconomic status. This should be the case at the population and individual levels, so that health disparities among populations are reduced.

In addition, the report calls for the health system to anticipate patients' needs, and customize care and train the health care workforce to meet these needs. It also mentions the importance of building organizational supports for change (e.g., information technology, development of teams, and coordination of care) and establishing a new environment for care (e.g., the use of incentives to encourage innovation and quality, routine monitoring, and accountability). In sum, *Crossing the Quality Chasm* has become both a clarion call for health system redesign, as well as the blueprint for achieving that end.

## **RACIAL/ETHNIC DISPARITIES IN HEALTH CARE: WHAT DO WE KNOW?**

The IOM report, *Unequal Treatment*, remains the preeminent study of the issue of racial and ethnic disparities in health care in the United States.<sup>10</sup> This report demonstrates that, in addition to racial and ethnic disparities in health status, there is evidence of racial and ethnic disparities in health care quality. Minorities may receive lower-quality care than their white counterparts, even after taking into account social determinants and insurance status. Two more recent studies conclude that racial and ethnic health disparities have persisted over the last decade, especially in the use of major procedures among the elderly

in the management of myocardial infarction.<sup>11</sup> This is the case despite a gradual increase in awareness of this issue among the health care providers.

*Unequal Treatment* identified a set of root causes of racial and ethnic disparities that included, among others:

1. **Health system factors:** These include issues related to the complexity of the health care system and how it may be disproportionately difficult to navigate the system for minority patients, as well as the presence or absence of interpreter services to assist patients with limited English proficiency.
2. **Care-process variables:** These include issues related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication.
3. **Patient-level variables:** These include refusal of services, poor adherence to treatment, and delay in seeking care.

These groupings sketch the “big picture” for the root causes of disparities.

## **IMPROVING QUALITY TO ADDRESS DISPARITIES**

### **Defining Cultural Competence**

In previous research, cultural competence in health care was found to entail: developing an understanding of the patient communities being served, as well as individual patients’ health beliefs and behaviors; considering how these factors interact with the health care system in ways that may prevent diverse populations from obtaining quality health care; and devising strategies to effectively address and monitor them through several interventions.<sup>12</sup> One framework for cultural competence in health care includes:

- **Organizational cultural competence:** increasing the diversity of the health care workforce and leadership. Organizational capacities, such as diversity in the leadership of health care delivery systems (including the board of trustees and senior management), diversity among staff and providers (including provider networks), and strategies for diversity in all hiring practices and recruitment, are critical.
- **Systemic cultural competence:** conducting community assessments and developing mechanisms for feedback; implementing collection of data on race/ethnicity and language preference; monitoring patient satisfaction by race/ethnicity; and ensuring

culturally and linguistically appropriate health education materials, signage, interpretation services, and health promotion and disease prevention interventions.

- **Clinical cultural competence:** using training and education to raise providers' awareness of how sociocultural factors affect health beliefs and behaviors; empowering patients to take active roles in medical encounters; improving communication across cultures; building trust between providers and patients, and between patients and the health system; and being attentive to the effects of race, ethnicity, and culture on clinical decision-making.

Several aspects of this framework for a culturally competent system of care have implications for general health care system quality, as well as for specific quality improvement initiatives.

### **Addressing General Health Care System Quality**

*Crossing the Quality Chasm* uses a clinical case to illustrate the deficits of our current health care system. The case covers many key issues, yet many would argue that they represent the experience of a patient in whom the root causes for health disparities—and key cross-cultural issues—are not on display. The following two clinical cases (created by the author, drawn from a composite of patient issues) illustrate how a system that is not culturally competent also fails on several principles of quality as defined by *Crossing the Quality Chasm*:

Mr. J is a 63-year-old man with limited English proficiency who presents to the emergency department, complaining that he has had a headache for several days. Mr. J has hypertension and high cholesterol. Several doctors try to obtain a history from him to determine the nature of his pain, yet have difficulty doing so given that no interpreter is available. After seven hours in the emergency department, Mr. J is finally sent for a head CT scan with contrast to rule out an intracranial bleed. An informed consent form is signed by the patient, but he really never knew what procedure he was about to undergo, nor did he understand the risks and benefits. Shortly after the CT scan—which was normal—Mr. J developed a severe allergic reaction to the contrast dye (his allergy history was never obtained because of the language barrier) and he required admission for overnight monitoring of his blood pressure and airway. His headache resolves shortly and later, through an interpreter, it is determined that his symptoms were simply due to inflamed sinuses given that he suffers from seasonal allergies.

The care Mr. J received falls short on several principles quality, as defined by the IOM report, and clearly falls short of high quality. First, Mr. J's care is not *timely*—he has

an extended wait time due to the absence of an interpreter. Second, Mr. J's care is not *efficient* or *effective*—an accurate medical history could not be obtained and as a result he is sent for a procedure that he doesn't need, is not supported by evidence-based guidelines, and is wasteful of resources. Finally, the absence of an interpreter highlights that his care was neither *patient-centered* nor *safe*. An allergy history is not taken and informed consent is not properly obtained because of a failure of the system to address his language barrier. As a result, he suffers an allergic reaction, leading to an avoidable hospitalization. In sum, his care does not meet quality standards, is not culturally competent, and may lead to disparities.

Addressing language barriers is just one aspect of cultural competence. Other aspects are illustrated by the following case:

Mrs. L is a 53-year-old female with a past medical history of mild asthma and pernicious anemia who saw her doctor recently and complained of some chest discomfort—or “atypical chest pain.” At that time, she was sent home with a diagnosis of gastroesophageal reflux, and given a prescription for a proton-pump inhibitor. About eight weeks later her symptoms have not resolved, so she is sent information to receive an “EGD,” but she doesn't understand the written materials very well as they are written in complicated language. When she shows up to get it done, she is sent home and told to reschedule because she ate breakfast. She gets the procedure done at a later date, and it is normal. Two days later she presents to the emergency department with a small myocardial infarction, and is scheduled for a cardiac catheterization. Again, she has difficulty understanding the information, and says she wants to discuss this with her sister tomorrow when she arrives from out of town, but is told she does not have the option and needs to decide immediately. She has trouble understanding why this is the case, and feels particularly mistrustful of the hospitalist. The next day she speaks to her sister and agrees to get the procedure, but is told she “missed her turn” and ends up waiting three more days. On the night prior to the procedure she is found to be a bit too anemic to undergo the catheterization (she has underlying anemia and had a significant amount of blood drawn over the last four days) and is offered a transfusion. When the doctor tries to get informed consent, he finds out she is a Jehovah's Witness and cannot accept blood products. She is treated with a red blood cell stimulation medication (aranesp), blood draws are minimized, and she gets the catheterization five days later.

Mrs. L's care highlights a system that is not culturally competent and leads to low-quality care. Particularly, we see that her care is not *timely*—in one instance due to receipt of materials written at too high a reading level given her limited health literacy, and in

another instance because her religion was not assessed upon hospital admission. Additionally, her care was not *patient-centered*, given she was told she did not have time to consult her family and no one attempted to address her mistrust, nor was it *safe* as she was misdiagnosed because of her health care providers' lack of familiarity with the body of evidence that shows women and minorities tend to present cardiac symptoms atypically.<sup>13</sup> Her care was not *efficient*, as she underwent an upper endoscopy when her work-up should have begun with a cardiac stress test.

In sum, lack of attention to issues related to cultural competence—including a failure to understand the patient's values and preferences, as well as health issues relevant to the patient's gender and race—led to misdiagnosis, a potentially avoidable myocardial infarction, and a prolonged length of stay. Although this case focuses primarily on the clinical encounter, several systems issues—such as lack of information at a general level of health literacy, as well as no routine or formal way of assessing the patient's religion—contributed to some of the problems.

*Crossing the Quality Chasm* presents a “model” case of a patient who receives care in a newly designed system that adheres to the six principles of quality, yet this model assumes that the patient has a high level of health literacy, as well as access to and proficiency in Internet use. The question remains whether this model—albeit innovative—takes into account the needs of diverse patient populations. To understand how cultural competence ties into efforts to address disparities and improve general health care system quality, it is helpful to closely examine the six IOM principles to identify areas where aspects of cultural competence would be central to achieving high quality.

**Safety:** According to the IOM report, patient safety is not solely about addressing general systems issues to prevent the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim (such as administering the wrong medication or dosage). It also includes:

- *avoiding misdiagnosis*, such as “diagnosing pneumonia when the patient has congestive heart failure”;
- *preventing patients from exposure to unnecessary risks*, such as inadvertent exposure to “chemicals, foreign bodies, trauma, or infectious agents;” and *ensuring informed consent*, such as requiring that patients be informed and participate in their care as fully as they wish and are able—and that patients and their families should not be excluded from learning about uncertainty, risks, and treatment choices.

*Linkage to cultural competence.* *Unequal Treatment* highlighted the importance of improving provider–patient communication as a method of addressing racial/ethnic disparities in health care. In particular, the report recommended that health care providers be trained in cross-cultural communication (clinical cultural competence) and that health care systems support the use of interpreter services for patients with limited English proficiency (systemic cultural competence). Improved communication through such means has the potential to:

- Improve the capacity of health care providers to make accurate diagnoses, particularly in areas where the medical history is a critical determinant of action and where non-specific or atypical, culturally influenced presentation of symptoms may cloud judgment. This includes clinical conditions such as cardiovascular disease (identification of angina versus gastroesophageal reflux); mental health (distinguishing between culture-bound syndromes and schizophrenia); and neurology (determining whether symptoms are caused by a migraine headache or a cerebrovascular accident).
- Prevent patients from exposure to unnecessary risks from diagnostic procedures (e.g., CT scans with contrast, cardiac catheterization) and medications (e.g., prescriptions for antipsychotics). Research has shown that, in the presence of a language barrier, health care providers without access to interpreters tend to order more tests to assist in making a diagnosis.<sup>14</sup> This might pose undue risks to patients, especially when an interpreter might significantly improve a clinician’s diagnostic capability.
- Enable providers to obtain truly informed consent and allow patients to participate in clinical decision-making (by facilitating learning about uncertainty, risks, and treatment choices). In addition to provider cross-cultural skills and interpreter services, written patient materials in different languages and at a low level of health literacy ensure that patients understand their options, choices, costs, and benefits.

*Effectiveness.* *Crossing the Quality Chasm* highlights the importance of using evidence-based guidelines to provide high-quality care. It defines “evidence-based practice” as the integration of the best research evidence with clinical expertise (skills to identify each patient’s unique health state and diagnosis, individual risks and benefits of interventions, and personal values and expectations) and patient values (unique preferences brought by each patient to the clinical encounter and must be integrated into clinical decisions). Thus, effectiveness is not only about providing care based on the best available evidence but also about consideration of patients’ preferences and values.

*Linkage to cultural competence.* Two aspects of cultural competence—systemic and clinical—can play a role in improving effectiveness. First, in order to ensure effective care, systems must be in place to detect health disparities by stratifying measures by race/ethnicity (as recommended in *Unequal Treatment*). This forms the basis for development of quality improvement activities to address racial/ethnic disparities in health care. Use of interpreter services as a vehicle for improving communication is also essential. Second, clinical cultural competence, which includes health care providers' ability to ascertain patient preferences and values, is a clear component of effectiveness.

***Patient-centeredness.*** *Crossing the Quality Chasm* states that compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient are the hallmarks of patient-centeredness.

*Linkage to cultural competence.* Many would agree that the key attitudes and skills defined as “patient-centered” are also central to clinical cultural competence. This includes the patient's ability to participate in decision-making, obtain the information they need, be heard, and participate in systems of care that are responsive to their needs. The key dimensions of patient-centered care and cultural competence include respect for patient's values, preferences, and expressed needs; trust; information, communication, and education; emotional support; and involvement of family and friends when desired. Of all the principles of the IOM report, patient-centeredness is perhaps the most closely linked to cultural competence—an affinity explicitly discussed in the report.

***Timeliness and efficiency.*** *Crossing the Quality Chasm* states that a timely system prevents patients from experiencing harmful delays in receipt of necessary services, and an efficient system avoids quality and administrative waste.

*Linkage to cultural competence.* Language barriers may contribute to increased length of stay in the hospital or longer wait times in an emergency department. Similarly, as described above, lack of interpreters may contribute to inappropriate test ordering.<sup>15</sup> Many such cases have been identified by practicing physicians, affecting both the timeliness and efficiency of care.<sup>16</sup> Thus, it should be acknowledged that systemic cultural competence could improve the timeliness and efficiency of a system by getting patients the services that are appropriate in an expeditious fashion.

***Equity.*** *Crossing the Quality Chasm* states that a system is high quality if it provides care that does not vary because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

*Linkage to cultural competence.* As described above, systemic cultural competence, which entails processes to monitor the quality of care and detect disparities by stratifying measures by race/ethnicity, is essential. Such measurement lays the foundation for targeted quality improvement activities. From the above, a set of process and outcome measures can be embedded into the six quality principles to ensure that aspects of cultural competence are attended to as part of the development of a high-quality system of care.

### **Addressing Specific Quality Improvement Initiatives**

It is helpful to review the key principles of disease management (DM) and the chronic care model (CCM)—the so-called “organized processes approaches”—to identify areas where aspects of cultural competence could be integrated into specific approaches to quality improvement. Traditionally, the CCM and DM have operated in “cookie-cutter” fashion, relying on technology, telephone contact, and case management. Such initiatives are not necessarily tailored to the needs of patients with limited English proficiency or focused on other issues that lead to disparities among minority populations. A review of the key principles of CCM and DM identifies areas where cultural competence could be embedded:

- ***Identify patients who need care:*** Since both the CCM and DM create registries of patients with specific chronic conditions (e.g., diabetes), a culturally competent approach would ensure that these registries are stratified by race, ethnicity, and language proficiency and thus geared to identify racial/ethnic disparities in health care.
- ***Provide care by tailoring the methods used to the patient’s needs:*** In CCM and DM initiatives, physicians, case management nurses, and other members of multidisciplinary care teams communicate with patients outside of the traditional office visit, for example through telephone contact, e-mail, and group visits. A culturally competency approach would establish ways to communicate with patients with limited English proficiency, limited health literacy, alternative health beliefs, and other needs. There are some existing models of culturally competent disease management.<sup>17</sup> In these instances, case management staff speak languages other than English, materials are available in multiple languages and at a low level of health and general literacy, and care management includes exploration of sociocultural barriers to care (e.g., barriers to adherence that include varying perspectives about illness or fears and concerns about medications) and a process to manage such issues when identified.<sup>18</sup>
- ***Support physicians and multidisciplinary teams in their clinical decision-making:*** Once sociocultural barriers to care are identified and interventions to address them are

put in place, physicians can be enlisted to help. For example, physicians might initiate discussions with patients about their understanding of their conditions, or their fears and concerns about a medication. Thus, physicians could play a timely role in addressing sociocultural barriers to care by following culturally competent approaches to decision support.

- ***Support patients in their ability to manage their own illnesses:*** The standard methods for supporting self-management have been described earlier in this report. To make this process culturally competent, educational information could be provided to patients in appropriate languages, and at appropriate levels for their general and health literacy. In addition, self-management advice and strategies could take into account key issues related to patients' social context, such as their physical environment and ability to exercise, their access to healthy foods, and the cultural traditions and customs that influence their dietary and exercise patterns.
- ***Provide physicians, teams, and physician organizations with feedback on their performance:*** Providing useful performance feedback requires collection of accurate and complete information, adjustment of that information for the severity of patients' medical conditions and socioeconomic status, and statistically reliable and valid analyses. Stratifying this information by race, ethnicity, culture, and language proficiency would enable health teams to identify issues as they arise for particular patients, and address them as they emerge in distinct populations.

Quality improvement programs that use multiple, coordinated processes are more effective than programs relying on only one approach.<sup>19</sup> DM and CCM programs should be tailored to meet the needs of all participants, including those with limited reading skills, poor or no telephone or internet access, diverse cultural and ethnic backgrounds, and primary languages other than English. It may also be necessary to shift the focus of such programs from “disease management” to “illness management,” taking into consideration the social and cultural factors that affect a patient's overall experience of illness.<sup>20</sup> Illness management would attempt to improve patients' experiences of their health conditions, as well as their clinical quality indicators. For instance, measures of success for diabetic patients would include not only an acceptable cholesterol level, but also how well they are coping with their condition.

A report from the National Initiative for Children's Healthcare Quality, *Improving Cultural Competency in Children's Health Care*, provides further examples of how the principles of quality improvement and cultural competency could be joined.<sup>21</sup> In their “Cultural Competence Change Package,” the authors describe—through a set of change concepts and potential strategies—how the care model for child health and key principles

of cultural competence could be pulled together to improve quality and address disparities. In addition, Aetna has embedded cultural competence strategies to address racial and ethnic disparities into their work with diabetes patients. These strategies include providing training to health coaches and low-health literacy and language-appropriate materials.

### **Quality, Cultural Competence, and Disparities: Hypotheses Versus Evidence**

This report attempts to link efforts in cultural competence to quality improvement as a method of addressing racial/ethnic disparities in health care. This does not just apply to adult medicine, but should be viewed as part of family-centered care and care throughout the life cycle. On its own, culturally competent care cannot—and should not be expected to—eliminate racial/ethnic health disparities. To achieve this ambitious goal, we must address the key social determinants (e.g., socioeconomic status, education, housing, and the environment) that contribute to disparities, expand access to care, and address the myriad health system factors that contribute to this problem. That being said, there are several obvious points of synergy between the principles of cultural competence and quality improvement. Yet, any analysis that attempts to link cultural competence efforts, or quality improvement generally, to the elimination of racial/ethnic health disparities faces the challenge that—while there are various promising interventions and strategies—the evidence of their effectiveness is scant. This is not because there are many studies dispelling the hypothesis that cultural competence and quality improvement can work together to address disparities, but because this theory has yet to be studied in great detail.

This analysis presents a framework to consider the interplay between cultural competence, quality, and racial/ethnic disparities in health care. It presents hypothetical interventions based on evidence as well as evidence of strategies that have been found to work. Tables 1 through 3 explore the root causes of disparities, how cultural competence might address them, and what other approaches outside of cultural competence are needed. Any efforts to address racial/ethnic disparities must be predicated on effective, standardized collection of race/ethnicity data, stratification of those data by race/ethnicity, and commitment to developing interventions to address disparities if and when they are found.

Table 1. Health System–Level Factors

<b>Root Cause of Disparities</b>	<b>Cultural Competence Strategies to Address Them</b>	<b>Other Strategies to Address Them</b>
Health system complexity  (system particularly complex for those with limited English proficiency, low health literacy, mistrust, and little familiarity with the Western model of health care delivery and practice)	Multilingual signage <sup>H</sup>  Interpreters <sup>E</sup>  Multilingual, low literacy written materials <sup>H</sup>  Culturally competent disease management <sup>E</sup>  Health care navigators <sup>E</sup>	General disease management <sup>E</sup>

Note: H=Hypotheses, E=Evidence.

Source: Author’s analysis.

Among the interventions listed above, there is clear evidence that interpreter use can improve doctor–patient communication, patient satisfaction, patients’ understanding of their conditions and follow-up instructions, and, by proxy, patient-centeredness.<sup>22</sup> There is also evidence to support the use of health care navigators—trained health professionals or lay community members who assist patients with specific conditions (such as an abnormal mammogram). Such navigators help patients maneuver their way through the health care system to obtain needed diagnostic or therapeutic procedures.<sup>23</sup> Similarly, several studies have highlighted the ability of general disease management to eliminate disparities in congestive heart failure, dialysis, and pneumococcal vaccination.<sup>24</sup> In addition, there are several emerging models of “culturally competent” disease management—disease management programs that also focus on sociocultural and linguistic barriers—that have proven successful in improving outcomes and addressing racial/ethnic health disparities in, for example, pediatric asthma and depression.<sup>25</sup> Although no definitive studies exist, it is likely that multilingual hospital signage and written materials requiring low levels of health literacy (such as for the preparation regimen for a colonoscopy or informed consent) would improve patients’ ability to take active roles in their care and thus improve quality.

Table 2. Care-Process Variables

<b>Root Cause of Disparities</b>	<b>Cultural Competence Strategies to Address Them</b>	<b>Other Strategies to Address Them</b>
Little attention or skill in dealing with patients from diverse sociocultural backgrounds leading to poor communication and clinical uncertainty	Cultural competence education <sup>H</sup>	
Provider stereotyping of patients leading to different recommendations for diagnostic or therapeutic procedures	Curricula on the impact of race/ethnicity on clinical decision-making <sup>H</sup>	Physician reminders (e.g., via electronic medical records) <sup>E</sup>
Providers caring for patients with limited-English proficiency in the absence of an interpreter	Interpreters <sup>E</sup>	Performance review, reporting, and detailing <sup>E</sup>

Note: H=Hypotheses, E=Evidence.

Source: Author's analysis.

Cultural competence education has been shown to improve the attitudes, knowledge, and skills of health care professionals regarding cross-cultural care, and at the same time improve patient satisfaction. Yet, no studies have demonstrated improvement in patient adherence or health outcomes, although many are currently underway.<sup>26</sup> It is also not clear how the introduction of medical curricula exploring the impact of patients' race and ethnicity on clinical decision-making might affect provider behavior. Physician reminders have been shown to improve quality by increasing the use of cancer screening.<sup>27</sup> Physician performance review, reporting, and academic detailing have been shown to improve overall quality of care in other areas.<sup>28</sup>

Table 3. Patient-Level Variables

<b>Root Cause of Disparities</b>	<b>Cultural Competence Strategies to Address Them</b>	<b>Other Strategies to Address Them</b>
Difficulty navigating the health care system	Health care navigators <sup>E</sup>	Patient reminders <sup>E</sup>
Mistrust and discomfort voicing concerns or asking questions of the provider	Patient activation programs <sup>H</sup>	

Note: H=Hypotheses, E=Evidence.

Source: Author's analysis.

There is evidence to support the use of patient reminders to increase rates of cancer screening, although not much evidence to date to support “patient activation” programs that attempt to empower patients to be proactive participants in their clinical encounters.<sup>29</sup> Hypothetically, this type of intervention should improve quality of care.

## **CONCLUSION**

Since the publication of *Crossing the Quality Chasm*, a broad movement has been set in motion to deliver on the promise of our health care system—that all patients receive the best care we have to offer, all of the time. There is clearly a long way to go, but the blueprint outlined in the report continues to be our guide. There is no panacea to achieve equity and eliminate disparities. Many believe the tools of general quality improvement will help get us there. Others believe that multiple assessment processes for understanding disparities in relation to diversity, cultural competence, and quality improvement in clinical practice might be more effective than quality improvement methodologies alone.<sup>30</sup> This innovative quality improvement methodology integrates both quantitative and qualitative techniques and produces a system-level understanding of organizations to guide quality improvement interventions. Ultimately, people of color may face barriers that our standard quality improvement tools may not fully address. Hypothetically, and with some preliminary evidence, it seems that quality improvement efforts will need to embed components of cultural competence to truly achieve equity. This process will require creativity and innovation.

Although the evidence base has yet to be fully developed, experts posit that cultural competence is an essential part of a portfolio of activities to improve quality and eliminate racial and ethnic disparities in health care.<sup>31</sup> The challenge ahead is to determine what aspects of cultural competence will achieve these goals, and what interventions in general quality improvement, unrelated to cultural competence, will achieve equity in health care.

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