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Cultural Competency: An Organizational Strategy for High-Performing Delivery Systems

EXECUTIVE SUMMARY

Disparities pervade healthcare to the point that healthcare in the United States is fundamentally unequal.[1] This inequity is a significant barrier to achieving high levels of healthcare quality. The quality of care a patient receives should not differ because of such characteristics as gender, race, education, disability, or location of residence. Clinicians should treat and respect each patient as an individual and in accordance with the principles of patient-centered care. The provision of culturally accurate and appropriate services—known as "culturally competent care"—is an integral component of any strategy to narrow the disparities gap. Culturally competent care strives to eliminate misunderstandings in diagnosis or in treatment planning that may arise from differences in language or culture and to improve patient adherence with treatments. This requires a partnership among clinicians, patients, and families. Culturally competent healthcare requires oral and written language access, sensitivity to cultural differences, attention to patients' health literacy needs, and consistency across settings, time, and providers. In order to achieve this vision, the National Quality Forum (NQF) identified guiding principles for culturally competent care and endorsed a framework for culturally competent care, consisting of domains and preferred practices.

Introduction

Equity—the fundamental premise in healthcare that access and quality should not vary because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status—is such an important aim that the Institute of Medicine (IOM) deemed it one of the six aims that comprise healthcare quality.[2,3] However, the U.S. healthcare system's quest for equity today falls well short of its ideals.[4]

Racial, ethnic, and economic disparities pervade healthcare quality. Evidence is clear that minorities receive a lower quality of care and suffer disproportionately from higher rates of disease and death even when factors such as access, health insurance, and income are taken into account.[5] These disparities are so persistent that it can fairly be said that the provision of healthcare in the United States is fundamentally unequal. Worse, this is not a new observation. Disparities in healthcare have been documented for decades, famously with the Department of Health and Human Services' (DHHS') Secretary Margaret Heckler's landmark 1985 report that revealed large and persistent gaps in health status among Americans of different racial and

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ethnic groups.[6] Moreover, despite widespread attention, it appears that little if any progress has been made in closing the disparities gap.[7] Until these disparities are targeted and eliminated, the U.S. healthcare system will be unable to achieve the aim of high levels of performance.

No one knows for certain why these disparities persist. It is likely that the reasons are multifaceted and may include lack of insurance coverage, lack of a regular source of care, lack of financial resources, legal barriers, literacy, poorer quality of care provided in minority geographic regions, and linguistic barriers. IOM noted that one major contributor to disparities in health and healthcare is a lack of culturally competent care.[8] Providing culturally appropriate services has the potential to reduce disparities and improve outcomes, while increasing patient satisfaction.

Cultural competency defies easy characterization. It is similar to patient-centeredness—another of IOM's six aims of quality—in that it calls for care that is focused on and serves the patient's needs and preferences, understanding that these may differ from patient to patient and across diverse population groups.[9] NQF defined cultural competency as:

> the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable (see Box 1).[10]

Numerous national healthcare organizations have taken steps to enhance cultural competency. The Joint Commission, the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and DHHS' Office of Minority Health all have undertaken initiatives to address cultural competency in some fashion. Although each organization approaches the concept slightly differently, a significant amount of work is convergent. Their work is complemented by The Opportunity Agenda, which focuses on integrating issues around disparities with such tools as online mapping initiatives and communications outreach programs.[11] These organizations and many others recognize that cultural competency is a critical component of both equity and patient-centered care; that equity and patient-centered care are critical components of high-quality healthcare; and thus that high-quality healthcare requires cultural competency.

The Stubborn Nature of Disparities and the Importance of Cultural Competency

Since 2003, the Agency for Healthcare Research and Quality (AHRQ) has rigorously documented pervasive and growing inequities in the U.S. healthcare system. The disparities, documented in AHRQ's annual *National Healthcare Disparities Report,* make it clear that although healthcare quality is rising, it is doing so at an unequal pace for certain populations, creating a widening gap in the care provided to some Americans as compared with others.[12] AHRQ's annual *National Healthcare Quality Report,*[13] published concurrently with the disparities report, indicates that quality is improving overall, albeit slowly. However, the disparities report makes it clear that variations in quality—according to race, age, income, insurance status, and geography—dampen the nation's rate of quality improvement. These disparities are reflected in a variety of measures and care settings.

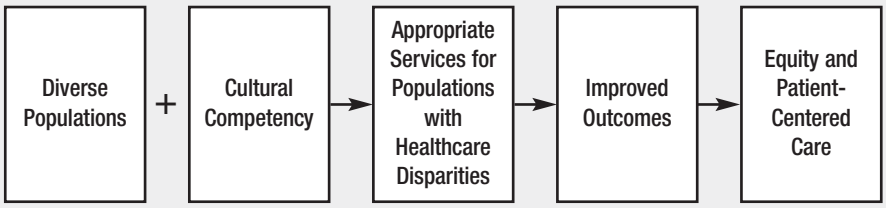
These facts—that national healthcare quality is improving, but slowly and at an unequal pace that exacerbates disparities—make it clear that even as the delivery of care improves overall, the provision of culturally accurate and appropriate services is required to avoid what may arise from differences in language or culture and to improve patient adherence with treatments (see Box 2). Hence, the rising tide of healthcare quality has not lifted all boats, and targeted efforts are required to address disparities in order to rectify this.

The evidence indicates that the nation's healthcare system still has much work to do. For example, one mostly overlooked but entrenched and critically important aspect of AHRQ's disparities report is the lack of racial and ethnic diversity in the healthcare workforce, particularly the nursing workforce. In 2004, 81.8 percent of registered nurses (RNs) in the United States were white. Relative to the nation's population at large, Latino, black, Asian, and American Indian or Alaskan Native individuals were underrepresented in the RN workforce, while whites were significantly overrepresented.

BOX 1 Definition of Cultural Competency

Cultural competency is the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable.

BOX 2 Reducing Health Disparities Through the Implementation of Cultural Competency



Adapted from Brach C, Fraser I, Can cultural competency reduce racial and ethnic health disparities? a review and conceptual model, *Med Care Res Rev*, 2000;57:187-217.

There were 1,238 white RNs per 100,000 white population, but just 119 Latino RNs per 100,000 Latino population and 359 black RNs per 100,000 black population.[14]

This lack of diversity is important because healthcare workforce diversity has the potential to improve cultural competency through culturally sensitive program design and policies, organizational commitment to culturally competent care, and cross-cultural education of colleagues. It also increases the opportunities for language-appropriate and culturally sensitive interaction between patients and providers.

In its report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,*[15] IOM called for a healthcare system in which the care a patient receives does not differ because of such characteristics as gender, race, age, ethnicity, income, education, disability, sexual orientation, or location of residence. The clinical quality should not differ, but clinicians should treat and respect each patient as an individual and in accordance with the principles of patient-centered care. This requires a partnership among clinicians, patients, and families to ensure that healthcare decisions take into account patient preferences. In order to be patient centered, evidence based, and equitable, culturally competent healthcare requires oral and written language access, sensitivity to cultural differences, and attention to the patients' health literacy needs. The delivery of culturally competent care should not focus on one specific clinical encounter, but rather should relate to the health and illness problems experienced by individuals and their families across the life span, including the variety of settings and providers.

Efforts to Address Cultural Competency

Many U.S. healthcare providers are taking active steps to address cultural competency. These include improved language interpretation programs, community health assessments, clinician training, and the provision of culturally sensitive, population-specific services. For example, Kaiser Permanente is using Centers of Excellence to analyze how different approaches to the provision of care can affect its quality among different populations, while NewYork-Presbyterian Hospital has improved its language interpretation services to ensure that communication is culturally sensitive as well as accurate. (See Case Study 1 and Case Study 2.) These localized efforts are bolstered by ongoing national efforts. In 2001, DHHS' Office of Minority Health published standards for culturally and linguistically appropriate services (CLAS) for healthcare organizations.[16] CLAS was an initial move to provide structure to what constitutes culturally appropriate healthcare services. NCQA now has an awards program for health plans that demonstrate innovative approaches in addressing CLAS standards and healthcare disparities.

Case Study 1: Kaiser Permanente

Most health systems apply the term "center of excellence" to clinical merit—such as specialization in cardiac care. Not Kaiser Permanente. Kaiser applies the term to models of service delivery targeting specific communities.

With 8.7 million health plan members and 37 medical centers in 9 states and the District of Columbia, Kaiser Permanente faces a broad challenge of engaging a patient population as diverse as the nation itself. Still, the organization views the diversity of its communities as an asset, not as a liability, says Winston F. Wong, MD, Kaiser's Medical Director of Community Benefit. "We've received the clear message from our leadership that cultural diversity is to be celebrated as a strength of the organization," Wong says.

In the late 1990s, Kaiser started developing centers of excellence to target minority populations, such as a Chinese center in San Francisco and a Latino center in Southern California. The goal: to demonstrate how to improve the care of targeted groups with consideration of their cultural, social, ethnic, and racial background.

Over time, these centers of excellence have gleaned important lessons on how to provide care that is culturally appropriate, sensitive, and competent to its many populations. For example, Kaiser is examining how language nuances affect patient-clinician interactions and how these can affect outcomes. "This allows us to dig deep into care patterns so we can identify potential gaps in clinical care—and do so in a way that the data can be trusted by our internal stakeholders and we can make improvements organization wide," Wong says.

From these centers of excellence, Kaiser developed learning modules on culturally sensitive care targeting specific populations. These learning modules include printed materials and video vignettes addressing such issues as how to deal with death and dying in a culturally appropriate manner and effective ways to enhance the doctor-patient relationship when clinician and patient come from differing cultural backgrounds.

Collection and sophisticated analyses of clinical and performance data have been critical to Kaiser's cultural competence work, because they identify disparities and highlight potential interventions. For example, buried deep within Kaiser's data were the revelations that Filipino men had among the highest smoking rates in the system's network; the data also revealed that this population was receiving comparatively less antismoking counseling during physician encounters. "When I presented these data internally, people were quite surprised," Wong says. "It generated some spontaneous movement among the staff—'Oh, yeah, this is something we should address.' And they did."

Smoking rates among Filipino men did drop. But Wong says that episode demonstrates that cultural competency is an uphill climb. "The persistence of disparities is sobering to all of us who work in this area," he says. "There is so much more we have to do."

Case Study 2: NewYork-Presbyterian Hospital

When J. Emilio Carrillo was 10 years old, he and his family fled his native Cuba for the United States. As political exiles, the Carrillos embraced the freedom of their new home, but life in New York as a struggling immigrant family was hard—especially when Carrillo's father got sick.

"I was the first one to learn English in my family, and the doctors couldn't speak Spanish, so it was up to me to interpret between my parents and the health system," Carrillo recalls. "As a kid, you're embarrassed and confused about how to handle that. It was very traumatic." He recalls how frustrated his father felt, and how circumspect the doctors were, because after all, they were talking to a child.

Today, Carrillo, a physician, is NewYork-Presbyterian Hospital's Vice President of Community Health Development, where he works to make sure that no child ever has to do what he had to do.

NewYork-Presbyterian Hospital features a state-of-the-art language interpretation program at its Washington Heights campus. The Washington Heights neighborhood of New York City, a vibrant, working-class community of 250,000 residents, is home to one of the largest and most diverse immigrant communities in the United States.

For more than 20 years, NewYork-Presbyterian has offered interpretation services. Five years ago, the hospital revamped its language interpretation program. In 2008, it provided more than 211,000 units of interpretation to patients and their families or surrogates—up 17 percent from 2007. Interpretation was provided in 95 languages; the top five were Spanish, Chinese, Russian, Arabic, and Bengali. At all hospital entry points, visitors are greeted with posters and cards in the 20 most commonly used languages, with guidance on how to proceed and navigate the system. "We want to make it as easy as possible for patients and their families to get care in the language with which they're most comfortable," Carrillo says.

The interpretation program goes beyond simple language to encourage culturally sensitive communication. Because in certain cultures, for example, the physician is seen as an authority figure, interpreters are taught specific ways to engage in conversation so the patient won't feel as if he or she is challenging the physician.

It costs NewYork-Presbyterian approximately $3 million a year to provide language interpretation services, and that money comes out of the hospital's pocket. But Carrillo views it as a non-negotiable patient safety issue. "It's harmful to everyone involved if you have a nonspecialist interpreting at the hospital, and we believe that our interpretation service prevents medical errors," he says.

In addition, The Joint Commission and CMS recently introduced policy-level approaches for cultural competency. The Joint Commission has nearly completed a project to develop hospital accreditation standards to promote, facilitate, and incentivize the provision of culturally competent, patient-centered care, and NCQA has been working to develop a module of standards suitable for evaluating efforts by managed care plans to improve the provision of culturally and linguistically appropriate services and to identify and reduce care deficiencies.

NQF Guiding Principles and Framework

Cultural competency is achieved through policies, learning processes, and structures by which organizations and individuals develop and support the attitudes, behaviors, practices, and systems that are needed for effective cross-cultural interactions.[17]

In order to promote culturally competent care and reduce healthcare disparities, in 2007 NQF undertook a project to identify and endorse a comprehensive national framework for measuring and reporting cultural competency across all healthcare settings, as well as a minimum set of preferred practices based on the framework.[18]

NQF observed that numerous research efforts sought to build an evidence base on cultural competency that would result in improved health outcomes, a sharper focus on the patient at the center of care, treatment of the patient as an individual rather than as a set of symptoms or illnesses, and decreased system costs. However, despite these research efforts, there was no broadly defined framework, logic model, or definition that would move the field beyond narrow interventions and toward broad-based, systemic practices.[19] A nationally endorsed framework around cultural competency can serve as a road map for the identification of a set of preferred practices and performance measures, as well as identify areas requiring additional research or development. NQF identified guiding principles for culturally competent care and endorsed a framework that consists of domains and preferred practices (see Box 3 on page 5).

The principles provide broad themes and direction that, if uniformly adopted by all stakeholders, promote standardized measurement and reporting, drive practice improvement and measure development, and support implementation. The guiding principles are intended to be overarching and/or cross-cutting across all (or multiple) of the domains.

The framework is based on a set of domains for standardizing measurement and reporting of high-quality, culturally competent care. These domains apply to multiple settings of care and providers of care. The domains are:

1. **Leadership** that recognizes that healthcare providers, clinical and organization leaders, governance boards, and the community share responsibility for and play an essential role in the development and implementation of cultural competency activities.

2. **Integration into Management Systems and Operations,** focusing on whether cultural competency is integrated throughout all management and operations of the organization.
3. **Patient-Provider Communication,** addressing all communication between patients and clinicians as well as support staff.
4. **Care Delivery Structures and Supporting Mechanisms,** encompassing the delivery of care, the physical environment where the care is delivered from the first encounter to the last, and links to supportive services and providers.
5. **Workforce Diversity and Training,** as a means to providing more effective services for culturally diverse populations through proactive recruitment and retention/promotion strategies.
6. **Community Engagement,** an active outreach and the reciprocal exchange of information, as well as community inclusion and partnership in organizational decisionmaking.
7. **Data Collection, Public Accountability, and Quality Improvement,** methodologies an organization uses to collect data necessary to assess its cultural competence (see Box 4).

Guided by the framework, preferred practices (and, ultimately, measures) should provide comprehensive evaluation and reporting tools to ensure that care is delivered in a culturally competent manner. The NQF framework consists of 45 endorsed preferred practices for measuring and reporting cultural competency. The practices suggest efforts such as partnering with community organizations to reach diverse populations; translating written materials into languages used by the local community; and implementing strategies to recruit and retain employees across all levels of the healthcare system that reflect local community demographics. Examples of practices include:

BOX 3 — Four Guiding Principles of Cultural Competency

1. Cultural competency in healthcare embraces the concept of equity, with patients having equal access to quality care and nondiscriminatory, patient-centered practices delivered by healthcare providers.
2. Cultural competency is necessary, but not sufficient, to achieving an equitable healthcare system.
3. Cultural competency should be viewed as an ongoing process and a multilevel approach, with assessments and interventions needed at the system, organizational, group, community, and individual levels. Cultural competency should not be viewed as an endpoint; rather, communities, organizations, and individuals should strive for continuous improvement.
4. The successful implementation of cultural competency initiatives to achieve high-quality, culturally competent, patient-centered care requires an organizational commitment with a systems approach. Addressing both organizational and clinical aspects when managing diversity and the needs of a diverse workforce, the surrounding community, and the patient population are important factors in providing culturally competent care.

BOX 4 — NQF's Primary Domains of Measuring and Reporting Cultural Competency

1. Leadership
2. Integration into Management Systems and Operations
3. Patient-Provider Communication
4. Care Delivery and Supporting Mechanisms
5. Workforce Diversity and Training
6. Community Engagement
7. Data Collection, Public Accountability, and Quality Improvement

- Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.
- Implement training that builds a workforce that is able to address the cultural needs of patients, and to provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.
- Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.
- Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking healthcare.

For more information on NQF's project, visit www.qualityforum.org/projects/ongoing/cultural-comp/index.asp.

Conclusion

Culture is central to the delivery of healthcare services. It influences patients' health beliefs, practices, attitudes towards care, and trust in the system and in individual providers.[20,21] Cultural differences affect how health information and healthcare services are received, understood, and acted upon.[22] Barriers to quality healthcare

occur when cultural differences are not adequately addressed, resulting in lower quality of care for culturally diverse populations. As such, addressing cultural differences becomes imperative, and high-performing healthcare organizations recognize cultural competency as an organizational strategy.[23]

Cultural competency is a necessary but, by itself, insufficient component of the equity and patient-centered aims of healthcare quality. Issues such as access, availability of primary care, and standardized measurement and public reporting all are essential components. Even so, it is clear that an emphasis on cultural competency will lead to a more equitable and patient-centered, and therefore higher-quality, health system.

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Notes

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NQF's mission is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

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