



**CULTURAL COMPETENCE IN HEALTH CARE:
EMERGING FRAMEWORKS AND PRACTICAL APPROACHES**

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FIELD REPORT

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Visit www.massgeneral.org/healthpolicy/cchc.html for a more detailed report that includes further information about the authors, interviews with key experts, and site visits; links to websites focused on cultural competence and racial/ethnic disparities; an autosearch engine for recent literature on cultural competence and racial/ethnic disparities; a guest book; and a searchable database of models of culturally competent care.

EXECUTIVE SUMMARY

As the United States becomes a more racially and ethnically diverse nation, health care systems and providers need to respond to patients' varied perspectives, values, and behaviors about health and well-being. Failure to understand and manage social and cultural differences may have significant health consequences for minority groups in particular.

The field of cultural competence has recently emerged as part of a strategy to reduce disparities in access to and quality of health care. Since this is an emerging field, efforts to define and implement the principles of cultural competence are still ongoing. To provide a framework for discussion and examples of practical approaches to cultural competence, this report set out to:

- Evaluate current definitions of cultural competence and identify benefits to the health care system by reviewing the medical literature and interviewing health care experts in government, managed care, academia, and community health care delivery.
- Identify models of culturally competent care.
- Determine key components of cultural competence and develop recommendations to implement culturally competent interventions and improve the quality of health care.

DEFINING CULTURAL COMPETENCE

Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Experts interviewed for this study describe cultural competence both as a vehicle to increase access to quality care for all patient populations and as a business strategy to attract new patients and market share.

BARRIERS TO CULTURALLY COMPETENT CARE

Barriers among patients, providers, and the U.S. health care system in general that might affect quality and contribute to racial/ethnic disparities in care include:

- Lack of diversity in health care's leadership and workforce.
- Systems of care poorly designed to meet the needs of diverse patient populations.
- Poor communication between providers and patients of different racial, ethnic, or cultural backgrounds.

BENEFITS OF CULTURAL COMPETENCE

The literature review revealed that few studies make the link directly between cultural competence and the elimination of racial/ethnic disparities in health care. Health care experts in government, managed care, academia, and community health care, on the other hand, make a clear connection between cultural competence, quality improvement, and the elimination of racial/ethnic disparities.

MODEL PRACTICE SITE VISITS

The authors visited an academic, government, managed care, and community health care program, each of which had been identified by experts interviewed in these fields as being models of cultural competence. Models studied included:

Academic Site Visit: White Memorial Medical Center Family Practice Residency Program, Los Angeles, CA

Support provided by the California Endowment to the White Memorial Medical Center Family Practice Residency Program enabled several faculty members, including a director of behavioral sciences, a manager of cross-cultural training, and a director of research and evaluation, to devote time specifically to cultural competence training. A medical fellowship position was also established with part-time clinical and supervisory responsibilities to provide a practical, clinical emphasis to the curriculum.

The curriculum, which is required, begins with a month-long orientation to introduce family medicine residents to the community. The doctors spend nearly 30 hours on issues related to cultural competence, during which time they learn about traditional healers and community-oriented primary care and hold small group discussions, readings, and self-reflective exercises. Throughout the year, issues related to cultural competence are integrated into the standard teaching curriculum and codified in a manual. Residents present clinical cases to faculty regularly, with particular emphasis on the sociocultural perspective. In addition, a yearly faculty development retreat helps to integrate cultural competence into all of the teaching at White Memorial. The hospital is currently assessing the outcomes of these interventions.

Government Site Visit: Language Interpreter Services and Translations, Washington State

Washington's Department of Social and Health Services launched its Language Interpreter Services and Translations (LIST) program in 1991, at a time when the state's immigrant and migrant populations began to grow. LIST runs a training and certification program—the only one of its kind in Washington—for interpreters and translators. It incorporates a sophisticated system of qualification, including written and oral testing and extensive

background checks. In addition, there is a quality control system, and the state provides reimbursement for certified or qualified interpreter or translation services for all Medicaid recipients and other department clients who need them. Requests for translation are typically generated by providers or the social service program staff, with eight languages readily available and all other languages accessible on-call. Interpreters bill costs directly to LIST and the rest of the department programs for services. The program also provides services for translation of documents.

Managed Care Site Visit: Kaiser Permanente, San Francisco, CA

Kaiser Permanente established a department of multicultural services that provides on-site interpreters for patients in all languages, with internal staffing capability in 14 different languages and dialects. A Chinese interpreter call center is also available to help Chinese-speaking patients make appointments, obtain medical advice, and navigate the health care system. A translation unit assures that written materials and signs are translated into the necessary languages. A cultural diversity advisory board was also established for oversight and consultation.

In addition, Kaiser has developed modules of culturally targeted health care delivery at the San Francisco facility. The multilingual Chinese module and the bilingual Spanish module provide care and services to all patients but have specific cultural and linguistic capacity to care for Chinese and Latino patients. Both modules are multispecialty and multidisciplinary. They include, for example, diabetes nurses, case managers, and health educators, with the entire staff chosen for its cultural understanding and language proficiencies.

On a national level, Kaiser Permanente has a director of linguistic and cultural programs. The California Endowment recently awarded Kaiser a grant to assess the outcomes of these programs and validate model programs for linguistic and cultural services. Kaiser Permanente's Institute for Culturally Competent Care now has six current and future centers of excellence, each with a different mission and focus: African American Populations (Los Angeles), Latino Populations (Colorado), Linguistic & Cultural Services (San Francisco), Women's Health, Members with Disabilities, and Eastern European Populations. Each center can be used as a model and site of distribution for materials, such as the culturally specific provider handbook, to other Kaiser Permanente programs.

Community Health Site Visit: Sunset Park Family Health Center Network of Lutheran Medical Center, Brooklyn, NY

In the early 1990s, the Sunset Park Family Health Center (SPFHC) began an effort to expand access to care for the recent Chinese immigrants in its area. The Asian Initiative would eventually become its first experience in creating culturally competent health care. However, the initiative was originally viewed by SPFHC leadership as an intervention in community-oriented primary care, an approach that was well-established in the organization's philosophy, mission, and history. The initiative focused at first on reducing barriers to care—offering flexible hours of service, establishing interpretation services and translating signage, forming stronger links to community leadership and key resources, and training Chinese-educated nurses in upgraded clinical skills so they could pass state licensing exams in English. This last effort, one that addressed the shortage of linguistically and culturally appropriate staff, reflects an institutional priority to recruit and hire from within the community.

Building on these efforts, SPFHC has made cultural competence an important goal, funding regular staff training programs, offering patient navigators, expanding its relationships with community groups, and creating an environment that celebrates diversity (e.g., by celebrating various cultural and religious holidays, displaying multicultural artwork, offering an array of ethnic foods, and creating prayer rooms).

The Mexican Health Project is one of several recent primary care sites targeting a rapidly growing immigrant community. When completed, the project will not only provide an assessment of community health needs but will recommend various interventions for communication in clinical settings and patient education.

RECOMMENDATIONS

To achieve *organizational cultural competence* within the health care leadership and workforce, it is important to maximize diversity. This may be accomplished through:

- Establishing programs for minority health care leadership development and strengthening existing programs. The desired result is a core of professionals who may assume influential positions in academia, government, and private industry.
- Hiring and promoting minorities in the health care workforce.
- Involving community representatives in the health care organization's planning and quality improvement meetings.

To achieve *systemic cultural competence* (e.g., in the structures of the health care system) it is essential to address such initiatives as conducting community assessments, developing mechanisms for community and patient feedback, implementing systems for patient racial/ethnic and language preference data collection, developing quality measures for diverse patient populations, and ensuring culturally and linguistically appropriate health education materials and health promotion and disease prevention interventions. Programs to achieve systemic cultural competence may include:

- Making on-site interpreter services available in health care settings with significant populations of limited-English-proficiency (LEP) patients. Other kinds of interpreter services should be used in settings with smaller LEP populations or limited financial or human resources.^a
- Developing health information for patients that is written at the appropriate literacy level and is targeted to the language and cultural norms of specific populations.
- Requiring large health care purchasers to include systemic cultural competence interventions as part of their contracting language.
- Identifying and implementing federal and state reimbursement strategies for interpreter services. Title VI legislation mandating the provision of interpreter services in health care should be enforced and institutions held accountable for substandard services.
- Using research tools to detect medical errors due to lack of systemic cultural competence, including those due to language barriers.
- Incorporating standards for measuring systemic cultural competence into standards used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and by the National Committee for Quality Assurance (NCQA).
- Collecting race/ethnicity and language preference data for all beneficiaries, members, and clinical encounters in programs sponsored by the federal government and private organizations.^b The data should be used to monitor racial and ethnic disparities in health care delivery, for reporting to the public, and for quality improvement initiatives.

^a This report endorses the report by the U.S. Department of Health and Human Services report, “Clarification of Title VI of the Civil Rights Act: Policies Regarding LEP Individuals.” It may be found at www.thomas.loc.

^b This paper endorses the detailed recommendations in Ruth T. Perot and Mara Youdelman, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (New York: The Commonwealth Fund, September 2001).

To attain *clinical cultural competence*, health care providers must: (1) be made aware of the impact of social and cultural factors on health beliefs and behaviors; (2) be equipped with the tools and skills to manage these factors appropriately through training and education; and (3) empower their patients to be more of an active partner in the medical encounter. Organizations can do this through:

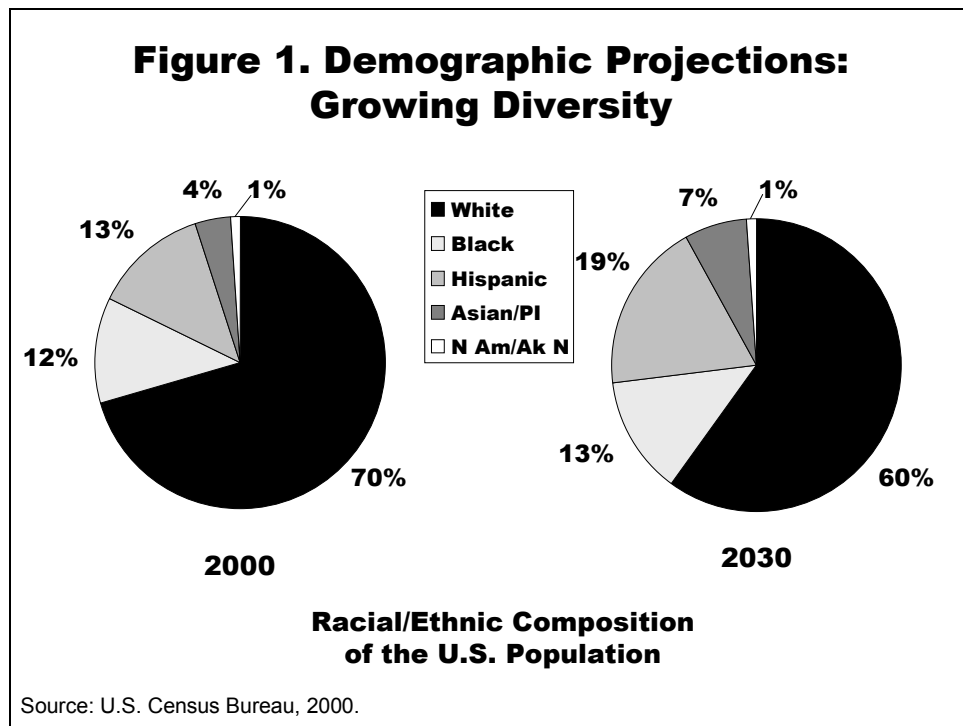
- cross-cultural training as a required, integrated component of the training and professional development of health care providers;
- quality improvement efforts that include culturally and linguistically appropriate patient survey methods and the development of process and outcome measures that reflect the needs of multicultural and minority populations; and
- programs to educate patients on how to navigate the health care system and become an active participant in their care.

**CULTURAL COMPETENCE IN HEALTH CARE:
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INTRODUCTION

Culture has been defined as an integrated pattern of learned beliefs and behaviors that can be shared among groups. It includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs.^{1,2} Culture is shaped by multiple influences, including race, ethnicity, nationality, language, and gender, but it also extends to socioeconomic status, physical and mental ability, sexual orientation, and occupation, among other factors. These influences can collectively be described as “sociocultural factors,” which shape our values, form our belief systems, and motivate our behaviors.

The 2000 United States Census confirmed that our nation’s population has become more diverse than ever before, and this trend is expected to continue over the next century (Figure 1).³ As we become a more ethnically and racially diverse nation, health care systems and providers need to reflect on and respond to patients’ varied perspectives, values, beliefs, and behaviors about health and well-being. Failure to understand and manage sociocultural differences may have significant health consequences for minority groups in particular.^c



^c The definition of “minority group” used in this paper is consistent with that of the U.S. Office of Management and Budget (OMB-15 Directive) and includes African Americans, Hispanics, Asian/Pacific Islanders, and Native Americans/Alaska Natives.

A number of factors lead to disparities in health and health care among racial and ethnic groups, including social determinants (e.g., low socioeconomic status or poor education) and lack of health insurance. Sociocultural differences among patients, health care providers, and the health care system, in particular, are seen by health care experts as potential causes for disparities. These differences, which may influence providers' decision-making and interactions between patients and the health care delivery system, may include: variations in patients' ability to recognize clinical symptoms of disease and illness, thresholds for seeking care (including the impact of racism and mistrust), expectations of care (including preferences for or against diagnostic and therapeutic procedures), and the ability to understand the prescribed treatment.⁴⁻¹³

The field of "cultural competence" in health care has emerged in part to address the factors that may contribute to racial/ethnic disparities in health care. Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency.

While cultural competence is widely recognized as integral to the elimination of disparities in health care, efforts are still ongoing to define and implement this broad construct.¹⁴⁻¹⁷ Legislators ask, for example, what policies can foster the cultural competence of our health care system. Administrators want to know what we can do to make managed care organizations or hospitals more culturally competent. Academicians ask what we should teach our health care professional students about cultural competence. Finally, providers ask how we can deliver more culturally competent care at the community level.

To address these questions, this report set out to:

- Review current definitions of cultural competence and identify benefits to health care, based on the medical literature and interviews with health care experts in government, managed care, academia, and community health care delivery.
- Identify models for achieving culturally competent care.
- Identify key components of cultural competence and develop recommendations for appropriate interventions.

FINDINGS

The literature review and interviews with experts yielded a practical definition of cultural competence in health care, highlighted sociocultural barriers that impair culturally competent care, and identified the benefits of culturally competent care.

DEFINING CULTURAL COMPETENCE

The literature review yielded various working definitions for cultural competence, with nearly all touching upon the need for health systems and providers to be aware of and responsive to patients' cultural perspectives.¹⁸⁻²⁰ All experts interviewed tended to see cultural competence as a way to increase access to quality care for all patient populations and as a business imperative to respond to diverse patient populations and attract new patients and market share.

These working definitions generally held that minorities have difficulty getting appropriate, timely, high-quality care because of language barriers and that they may have different perspectives on health, medical care, and expectations about diagnosis and treatment. Achieving cultural competence in health care would help remove these barriers, supplanting the current one-size-fits-all approach with a system more responsive to the needs of an increasingly diverse population.

“Cultural competence is a set of behaviors and attitudes and a culture within the business or operation of a system that respects and takes into account the person’s cultural background, cultural beliefs, and their values and incorporates it into the way health care is delivered to that individual.”

— Administrator, Managed Care Organization

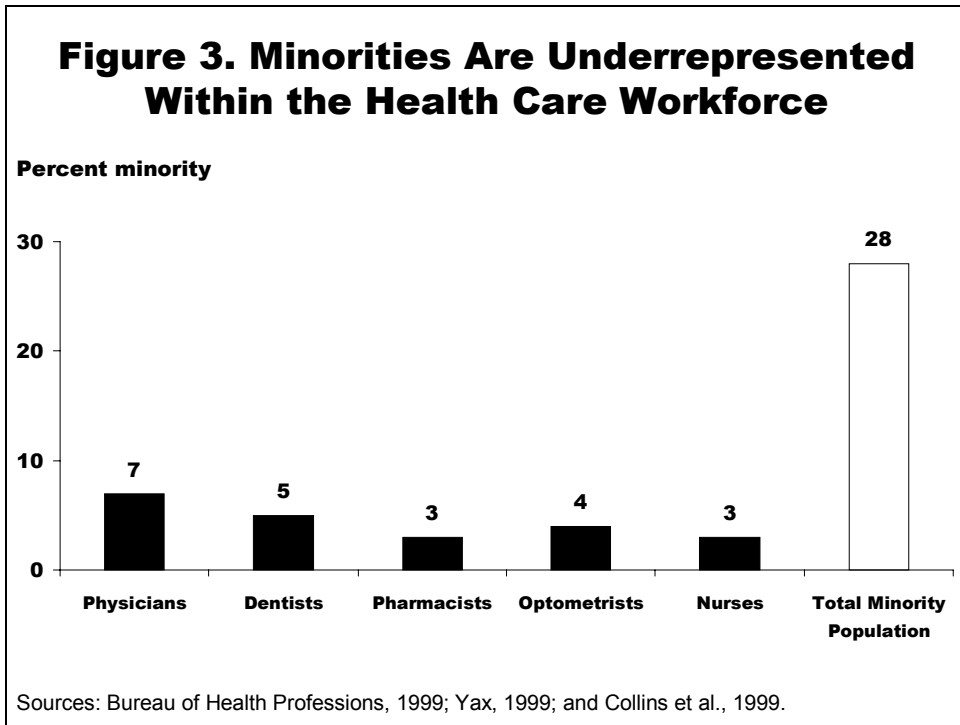
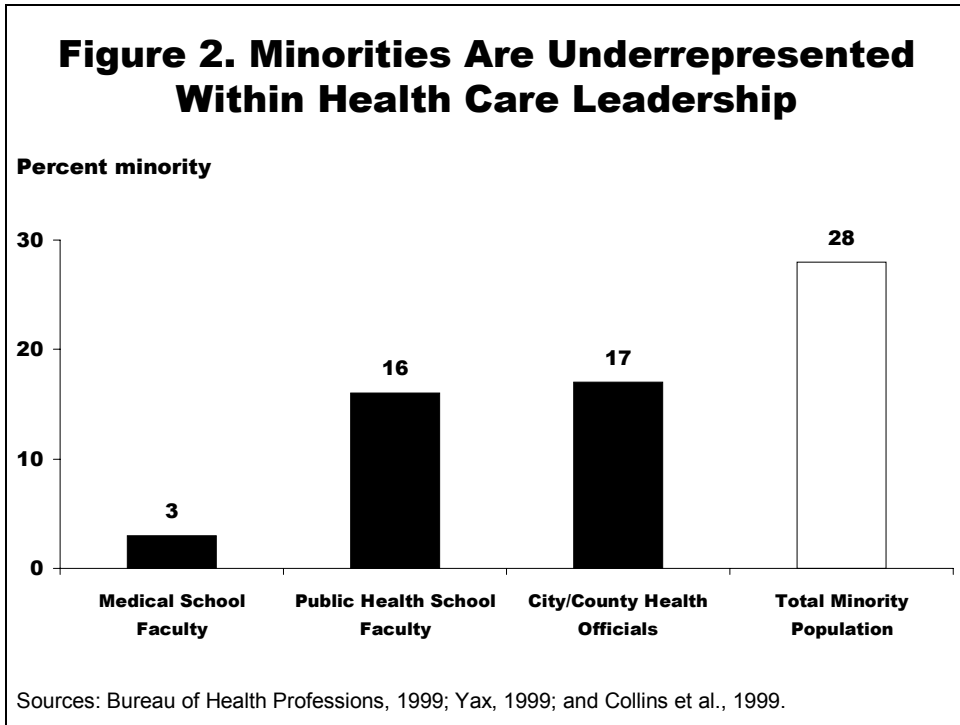
BARRIERS TO CULTURALLY COMPETENT CARE

The literature review and interviews identified sociocultural barriers among patients, providers, and the health care system that might affect quality and contribute to racial and ethnic disparities in care.

Lack of Diversity in Health Care Leadership and Workforce

Many journal articles and several key informants cited the lack of diversity in health care leadership as a potential barrier to care. Minorities make up 28 percent of the U.S. population but only 3 percent of medical school faculty, 16 percent of public health school faculty, and 17 percent of all city and county health officers (Figure 2).²¹ Furthermore, fully 98 percent of senior leaders in health care management are white.²² This is a major concern because minority health care professionals in general may be more

likely to take into account sociocultural factors when organizing health care delivery systems to meet the needs of minority populations.²³



Minorities are also underrepresented in the health care workforce (Figure 3). Several studies pointed to links between the racial and ethnic diversity of the health care workforce and health care quality. For example, studies have found that when there is racial concordance between doctor and patient—that is, when they share the same racial or ethnic background—patient satisfaction and self-rated quality of care are higher.^{24–26} Higher satisfaction and self-rated care are, in turn, closely linked to certain health outcomes, including more effective blood pressure control.^{27–29} Other work has established that minority physicians disproportionately serve minority and underserved communities.^{30–32}

“If we don’t have at the table people of color and the diverse populations we serve, you can be sure that policymaking and program design are also going to be exclusionary as well...and we’re going to continue to have disparities if we don’t start increasing diversity in the health professions.”

— CEO, Public Hospital

Systems of Care Poorly Designed for Diverse Patient Populations

Various systemic issues were raised in the literature and by the health care experts interviewed, including poorly constructed and complicated systems that are not responsive to the needs of diverse patient populations.³³ The issue of language discordance between provider and patient was foremost.³⁴ Systems lacking interpreter services or culturally and linguistically appropriate health education materials lead to patient dissatisfaction, poor comprehension and adherence, and lower-quality care, according to various studies.^{35–43}

“Our health care system is complicated for all...you can just imagine trying to navigate it if you have limited-English proficiency or a different understanding of health and health care.”

— Practicing Physician and Faculty Member, Academic Health Center

Poor Cross-Cultural Communication Between Providers and Patients

Experts and articles noted that other communication barriers, apart from language barriers, lead to disparities in care.⁴⁴ When health care providers fail to understand sociocultural differences between themselves and their patients, the communication and trust between them may suffer. This in turn may lead to patient dissatisfaction, poor adherence to medications and health promotion strategies, and poorer health outcomes.^{45–56} Moreover, when providers fail to take sociocultural factors into account, they may resort to stereotyping, which can affect their behavior and clinical decision-making.⁵⁷

“Being able to communicate with people with different social mores, different languages, different views, different religions—it’s a means of overcoming the barriers that have been created in the systems and messages we’re presenting.”

— Administrator, U.S. Department of Health and Human Services

BENEFITS OF CULTURAL COMPETENCE

While many have postulated that cultural competence will lead to a reduction in racial and ethnic disparities in health care, only a few studies have found direct links between cultural competency and health care improvement.⁵⁸⁻⁶² The medical literature that does make an explicit connection centers on the need to address language barriers between providers and patients and to train providers to care for diverse patient populations.

Experts interviewed, on the other hand, drew clear links among cultural competence, quality improvement, and the elimination of racial or ethnic disparities in care. While acknowledging many causes for such disparities, they regarded efforts to improve quality through greater cultural competence at multiple levels as especially important. Experts also stated that culturally competent adjustments in health care delivery would further the quality improvement movement as a whole and should occur at the systemic and clinical encounter levels.

“What we’re talking about in terms of cultural competency...is providing quality care to individuals who in the past have not received it...and when I think of quality care, that’s what we’re looking for for all Americans.”

— Administrator, U.S. Department of Health and Human Services

Experts described the need to use tools and benchmarks to evaluate outcomes—creating a standard of care for evaluation of care. They saw a need to translate cultural competence into quality indicators or outcomes that can be measured. They saw this, in and of itself, as a tool with which to eliminate barriers and disparities.

“Cultural competence is being talked about a lot and it is a beautiful goal, but we need to translate this into quality indicators or outcomes that can be measured, monitored, evaluated, or mandated.”

— Administrator, Community Health Center

MODELS OF CULTURALLY COMPETENT CARE

The authors visited four programs identified by experts as models of culturally competent care. The site visits were aimed at assessing the history, development, structure, process, supports, strengths, challenges, and impact of cultural competence interventions in academia, government, managed care, and community health care.

ACADEMIA

White Memorial Medical Center Family Practice Residency Program, Los Angeles, CA

The family practice residency program at White Memorial Medical Center began in 1988 with an explicit mission to serve the local community. The program also wanted to establish partnerships with local high schools and colleges to develop a pipeline for training students who could eventually serve the health needs of their own communities.

The area served by the facility is predominantly Mexican American, and half the population speaks mostly Spanish. About half the residents are insured through Medicaid, while the rest are either uninsured or have private insurance. Since the program's inception, White Memorial has emphasized the importance of cultural issues both outside and inside the medical encounter, but the formalization of the cross-cultural curriculum began in the late 1990s. Support from the California Endowment made it possible for several faculty members, including a director of behavioral sciences, a manager of cross-cultural training, and a director of research and evaluation, to devote time specifically to cultural competence training. A medical fellowship position was also established with part-time clinical and supervisory responsibilities to provide a practical, clinical emphasis to the curriculum.

The curriculum, which is required, begins with a month-long orientation to introduce family medicine residents to the community. The doctors spend nearly 30 hours on issues related to cultural competence, during which time they learn about traditional healers and community-oriented primary care and hold small-group discussions, readings, and self-reflective exercises. Throughout the year, issues related to cultural competence are integrated into the standard teaching curriculum and codified in a manual. Residents present clinical cases to faculty regularly, with particular emphasis on the sociocultural perspective. In addition, a yearly faculty development retreat helps to integrate cultural competence into all of the teaching at White Memorial. The hospital is currently assessing the outcomes of these interventions.

Key Lessons Learned

- Conduct a needs assessment of residents before curriculum development, create a multidisciplinary teaching team, and carve out time for faculty development. Include both minority and nonminority staff as faculty.
- Develop awareness and emphasize cross-cultural issues during orientation to help set the tone for the entire program.
- Integrate components of cultural competence into many different aspects of the educational curriculum—seminars, lectures, workshops—so the effort is not viewed as an added burden to an already busy resident schedule. Integrating cultural competence with clinical/biomedical education also prepares physicians on all levels.
- Evaluate the program at multiple levels, including cultural awareness, knowledge, and skills assessment.
- Determine means of gaining consensus for this type of curriculum, such as modifying hospital culture to keep up with the changing demographics of the community, performing public relations, securing federal funding and foundation grants, and fulfilling regulatory requirements.
- Secure faculty time, teaching time, and funding for cultural competence curriculum.

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GOVERNMENT

Language Interpreter Services and Translations, Washington State

Washington's Department of Social and Health Services launched its Language Interpreter Services and Translations (LIST) program in 1991, at a time when the state's immigrant and migrant populations began to grow. A series of lawsuits filed by the Office of Civil Rights in the mid-1980s provided the impetus for LIST's development. Washington's Medicaid and public assistance programs were not providing interpreters and translation services for consumers with limited English proficiency (LEP) and were therefore violating claimants' rights to equal access to services under federal law. In a predetermination

settlement, the state developed an administrative remedy to guarantee “equal access” to services for LEP consumers by providing interpreter and translation services. This broad definition of equal access to include language is the underpinning of the program and has been integral to its success. The current policy states clients with limited or no English are offered translation assistance at no cost. Most department literature, from brochures to forms, is available in seven languages. Other written material is summarized in the client’s language or an interpreter is provided.

LIST runs a training and certification program—the only one of its kind in Washington—for interpreters and translators. It incorporates a sophisticated system of qualification, including written and oral testing and extensive background checks. In addition, there is a quality control system, and the state provides reimbursement for certified or qualified interpreter or translation services for all Medicaid recipients and other department clients who need them. Requests for translation are typically generated by providers or the social service program staff, with eight languages readily available and all other languages accessible on-call. Interpreters bill costs directly to LIST and the rest of the department programs for services. The program also provides services for translation of documents.

Key Lessons Learned

The initiatives of Washington’s Department of Social and Health Services are unique to its historical and demographic setting, yet the framework may be applicable to other programs.

- Use existing structures to integrate new initiatives into the system. In this instance, legal and policy definitions of “equal access to services” meant that limited-English patients who were not offered interpretation or translation were, in effect, denied access. This led to the development of LIST and to the inclusion of language services in all programs of Washington’s Department of Social and Health Services.
- Collaborate with federal partners to increase funding support. Funding is available through matching funds from the federal Medicaid program. Funds are bundled in the category of administrative or client services and are available to all states. Washington receives a client services match for interpreter services to eligible LEP Medicaid clients and an administrative match for all other Medicaid-eligible services; these include, but are not limited to, drug, alcohol, and mental health treatment, and personal care services for children and the elderly.

- Establish reliable systems for data collection, assessment, and evaluation. A state program to reimburse interpreters should have checks in place to avoid interpreter abuses (e.g., double billing, soliciting patients directly, or high incidental costs).
- Establish mechanisms for standard interpreter certification, testing, and monitoring.
- Include a component to assess the reading level of written materials and translations.

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MANAGED CARE

Kaiser Permanente, San Francisco, CA

In the early 1990s, studies showed that Asian populations were the least satisfied with their health care within Kaiser Permanente’s Northern California Region. As a result, many Chinese American–owned and –operated companies were exploring health care contracts with smaller managed care organizations that were marketing services targeted to Chinese American consumers. To understand this issue better, the San Francisco Medical Center embarked on the “Chinese Initiative.” Based on findings of this initiative, Kaiser Permanente established a department of multicultural services that provides on-site interpreters for patients in all languages, with internal staffing capability in 14 different languages and dialects. A Chinese interpreter call center is also available to help Chinese-speaking patients make appointments, obtain medical advice, and navigate the health care system. A translation unit assures that written materials and signs are translated into the necessary languages. A cultural diversity advisory board was also established for oversight and consultation.

In addition, Kaiser has developed modules of culturally targeted health care delivery at the San Francisco facility. The multilingual Chinese module and the bilingual Spanish module provide care and services to all patients but have specific cultural and linguistic capacity to care for Chinese and Latino patients. Both modules are multispecialty and multidisciplinary. They include, for example, diabetes nurses, case managers, and

health educators, with the entire staff chosen for its cultural understanding and language proficiencies.

Much of the stimulus for this work came from the large purchasers of Kaiser health care services, who wanted culturally competent care for their employees. Not only had it become clear that culturally competent services made good business sense for Kaiser, but there was also a need to comply with Title VI of the Civil Rights Act and the Culturally and Linguistically Appropriate Services (CLAS) Standards.^d Today, San Francisco Medical Center is recognized as a center of excellence for linguistic and cultural services.

On a national level, Kaiser Permanente has a director of linguistic and cultural programs. The California Endowment recently awarded Kaiser a grant to assess the outcomes of these programs and validate model programs for linguistic and cultural services. Kaiser Permanente's Institute for Culturally Competent Care now has six current and future centers of excellence, each with a different mission and focus: African American Populations (Los Angeles), Latino Populations (Colorado), Linguistic & Cultural Services (San Francisco), Women's Health, Members with Disabilities, and Eastern European Populations. Each center can be used as a model and site of distribution for materials, such as the culturally specific provider handbook, to other Kaiser Permanente programs.

Key Lessons Learned

- Use publicity, market influences (including strategies to increase market share in diverse communities), and health care purchasers to stimulate the development of culturally competent services.
- Be careful in mandating cultural competence initiatives as this may lead to resentment, poor adherence to policies, and superficial responses.
- Employ multicultural managers to reflect the diversity of the staff and patients and to emphasize diversity throughout the organization.
- Focus the entire organization on the opportunity to improve services and business as a whole, including improvement in patient satisfaction.
- Implement systemic changes such as establishing a linguistically appropriate patient call center to help patients navigate the health care system.

^d The federal Office of Minority Health developed the Culturally and Linguistically Appropriate Services Standards project. See www.omhrc.gov/clas.

- Establish a cultural diversity board that includes administrators as well as a multidisciplinary group of providers (i.e., doctors, physician assistants, nurse practitioners, and registered nurses) and community representatives to help guide the delivery of culturally competent care.

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COMMUNITY HEALTH

Sunset Park Family Health Center Network of Lutheran Medical Center, Brooklyn, NY

In response to the overwhelming need for primary care in the underserved neighborhoods of southwest Brooklyn in New York City, Lutheran Medical Center created the Sunset Park Family Health Center (SPFHC). Funded more than 30 years ago in the second wave of federally supported community health centers, SPFHC is continually adjusting to changing demographics and community health needs in its surrounding area. Today, SPFHC consists of a network of primary care sites, a behavioral health center, school-based health centers, family support and literacy programs, community-sited health education and wellness centers, and a wide array of other supportive programs.

The impetus for developing a community-oriented, culturally competent approach originated with the need to define health in a more holistic manner. Because of the poverty and underdevelopment of the neighborhood, Lutheran employed a broad definition of community health and well-being that includes adequate housing, employment opportunities, educational opportunities, and civic participation, in addition to the reduction of medical illness.

For decades, Sunset Park has attracted immigrants. At first, Scandinavian workers gravitated to the area, followed by Puerto Ricans in the 1940s. Today, the community includes many of the long-settled ethnic groups as well as newer Chinese, Mexican, Central and South American, Dominican, Russian, and Middle Eastern populations, among others.

In the early 1990s, SPFHC began an effort to expand access to care for the recent Chinese immigrants in its area. The Asian Initiative would eventually become its first experience in creating culturally competent health care. However, the initiative was originally viewed by SPFHC leadership as an intervention in community-oriented primary care, an approach that was well-established in the organization's philosophy, mission, and history. The initiative focused at first on reducing barriers to care—offering flexible hours of service, establishing interpretation services and translating signage, forming stronger links to community leadership and key resources, and training Chinese-educated nurses in upgraded clinical skills so they could pass state licensing exams in English. This last effort, one that addressed the shortage of linguistically and culturally appropriate staff, reflects an institutional priority to recruit and hire from within the community.

Building on these efforts, SPFHC has made cultural competence an important goal, funding regular staff training programs, offering patient navigators, expanding its relationships with community groups, and creating an environment that celebrates diversity (e.g., by celebrating various cultural and religious holidays, displaying multicultural artwork, offering an array of ethnic foods, and creating prayer rooms).

The Mexican Health Project is one of several recent primary care sites targeting a rapidly growing immigrant community. When completed, the project will not only provide an assessment of community health needs but will recommend various interventions for communication in clinical settings and patient education.

Key Lessons Learned

- Form partnerships with community-based organizations to help establish culturally competent, community-oriented primary care. Such an approach makes good business sense, especially in a demographically changing environment.
- Define health and well-being in the broadest possible sense. Develop a mission statement and vision that reflect the principles of community-oriented primary care.
- Establish a governing body that helps identify unmet needs and provides feedback.
- Look for creative uses of available resources, both internally (i.e., staff) and externally (such as websites that provide demographic information).
- Cultural competence should not be a stand-alone process or outcome but should be integrated into all levels of the organization.

- Measure success by high levels of patient satisfaction, good clinical outcomes, fewer barriers to accessing care, and ongoing collaborative relationships with community leadership and organizations. Many of these indicators are included in SPFHC’s performance monitoring process and its quarterly report cards.

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KEY COMPONENTS OF CULTURAL COMPETENCE

The authors found that cultural competence in health care requires an understanding of the communities being served as well as the sociocultural influences on individual patients’ health beliefs and behaviors. It further requires understanding how these factors interact with the health care system in ways that may prevent diverse populations from obtaining quality health care. Finally, it entails devising strategies to reduce and monitor potential barriers through interventions. Based on the literature review, interviews, and site visits, key components of cultural competence have been identified in order to serve as a practical and effective framework for defining cultural competence in health care. These components also provide a framework for the implementation of culturally competent practices.

FRAMEWORK FOR CULTURALLY COMPETENT CARE

Organizational Cultural Competence

The nation’s health care systems and health policies are shaped by the leaders who design them and the workforce that carries them out. The literature, as well as the key experts interviewed, emphasized the importance of racial and ethnic diversity in health care leadership and the health care workforce. Leadership of delivery systems, boards of trustees and senior managers, staff, and providers (including provider networks) must all reflect diversity. Strategies for diversity in all hiring and recruitment practices are critical. Experts frequently noted the importance of involving community members in the health care process and suggested formally including culturally diverse community health advocates or mentors and recruiting staff from different communities.

Systemic Cultural Competence

Although systemic barriers to care can affect white patients and others of low socioeconomic status equally, minority populations face additional barriers. Those interviewed often cited systems that lack interpreter services or culturally and linguistically appropriate health education materials. Their perspectives were confirmed by studies in which language barriers in the health care system were linked to patient dissatisfaction, poor comprehension and compliance, and lower quality care.⁶³⁻⁶⁶ Health systems have a limited capacity to deliver quality care to diverse patient populations if they do not survey patients about satisfaction with care or request feedback for quality improvement, or if they do not integrate community perspectives into health planning.⁶⁷ Systems also need to collect data on race/ethnicity and language preference to plan for interpreter services and monitor for disparities in quality.⁶⁸

Clinical Cultural Competence

The literature, key experts, and site visits all confirmed the importance of sociocultural factors in the clinical encounter and highlight the importance of cross-cultural education and training.^{69,70} Training, which may include education in cultural competence for senior management, health care providers, and staff, should focus on knowledge and skills and equip providers to deliver quality care to all patients. Systems must be in place, however, to facilitate this goal. Curricula should be standardized and evidence-based, with appropriate monitoring to ensure completion (i.e., taking courses as part of being in a provider network, as a way of distinguishing health plans, or as part of licensure). Curricula, furthermore, must be devoid of stereotypes in their descriptions of ethnic group characteristics.

Training should also incorporate socioeconomic factors, communication skills, and mechanisms for addressing racism and bias. Finally, many experts noted that patient empowerment is an important facet of cultural competence.

STRATEGIES FOR IMPLEMENTATION

Among the strategies suggested for attaining cultural competence were using the influence of health care purchasers (government and private), developing contractual requirements (federal and state), and formulating accreditation standards (e.g., for hospitals and medical schools). Experts agreed that health care purchasers, both public and private, can help stimulate change if they understand the problems associated with health care delivery that lacks cultural competence.

“The trick of course is getting the purchaser to be interested and educated enough about cultural competence to be able to develop the right policy...and so that makes the purchaser-advocate partnership really critical.”

— Executive Director, Health Care Consulting Firm

Experts also cited the importance of the Centers for Medicare and Medicaid Services, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and state health care provider licensure and medical school accreditation organizations, as well as the need to make the “business case” for cultural competence.

Those interviewed also felt that the quality improvement movement was one of the strongest levers to advance the field. They unanimously agreed that, in theory, purchasers can facilitate cultural competence. However, they voiced skepticism about whether this would actually occur, given the multiple competing interests (e.g., from rising health care costs and premiums to drug costs) purchasers face along with their lack of knowledge about the issue.

Experts mentioned two initiatives that could advance the process. First, incorporating culturally competent measures or health disparity indicators as part of the Health Plan Employer Data and Information Set (HEDIS) would allow employers and purchasers to respond to evidence-based outcomes. Data should reflect the clinical impact of interventions, such as reducing hospitalization, increasing satisfaction, and improving market share and member loyalty. The second initiative would involve educating employees about disparities and cultural competence and empowering them to request more culturally appropriate services from the managed care provider their employer has retained. Regulatory methods, aside from those employed by the Joint Commission on Accreditation of Healthcare Organizations, were mentioned less frequently. In general, experts suggested a combination of information, research, and activism to facilitate cultural competence in managed care.

Many experts cited considerable variance among medical schools and residency training programs in the inclusion and quality of cultural competence training. Also of concern was the fact that few faculty members are interested in or have the skills and awareness to teach cultural competence. Funding opportunities, such as those that would allow for faculty development, or devoted time for curriculum development, were seen as potential incentives to move the field forward.

“I think the funding issue is particularly relevant for medical education...very often just getting things started is enough to allow things to happen. But you have to make that initial commitment. And even with the best intentions, sometimes it actually takes resources—and the resources are usually dollars.”

— Physician and Medical Education Administrator

SUMMARY OF RECOMMENDATIONS AND PRACTICAL APPROACHES: LINKING CULTURAL COMPETENCE TO THE ELIMINATION OF RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

Recommendations to achieve *organizational cultural competence* focus on promoting minorities into positions of leadership in health care and recruiting minorities into the health professions.^e *Systemic cultural competence* recommendations focus on eliminating systemic or institutional barriers to care and improving the health care system's ability to monitor and improve the quality of care. *Clinical cultural competence* recommendations center on enhancing health professionals' awareness of cultural issues and health beliefs while providing methods to elicit, negotiate, and manage this information once it is obtained.

ORGANIZATIONAL CULTURAL COMPETENCE

- Programs that advance minority health care leadership should be encouraged and existing programs should be strengthened in order to develop a cadre of professionals who may assume influential positions in academia, government, and private industry.
- Organizations should make it a priority to hire and promote minorities in the health care workforce.
- Community representatives should be formally or informally involved in the health care organization's planning and quality improvement meetings, whether as part of the board or as part of focus groups, for example.

SYSTEMIC CULTURAL COMPETENCE

- On-site interpreters should be available in health care settings where a significant proportion of patients has limited English proficiency (LEP)—for example, more than 15 percent. Other types of interpreter services, such as remote telephone or simultaneous interpretation, should be used in settings with fewer LEP patients or with limited financial or human resources.^f
- Key health information should reflect the appropriate level of health literacy, language proficiency, and cultural norms for the populations being served. This

^e This report endorses the more detailed recommendations in the Institute of Medicine's report, *The Right Thing to Do; The Smart Thing To Do: Enhancing Diversity in the Health Professions* (Washington, D.C.: National Academy Press, 2001).

^f This report endorses the report of the U.S. Department of Health and Human Services on "Clarification of Title VI of the Civil Rights Act: Policies Regarding LEP Individuals." It is on the Internet at www.thomas.loc.

includes signage, specific programs for health promotion and disease prevention, health education materials, pre- and post-procedure instructions, informed-consent forms, and advanced directives, among other materials.

- Large health care purchasers, both private and public, should require systemic cultural competence interventions (e.g., racial and ethnic data collection, interpreter services) as part of their contracting language.
- Organizations should identify federal and state reimbursement strategies for interpreter services.
- The federal government should enforce Title VI requirements mandating the provision of interpreter services in health care settings. Institutions should be held accountable for substandard services.
- Researchers should identify tools to detect medical errors that result from lack of systemic cultural competence, including those stemming from language barriers (e.g., taking a prescribed medication incorrectly); misunderstanding health education materials, instructions, or signage (e.g., inappropriately preparing for a diagnostic or therapeutic procedure, resulting in postponement or delay); and misunderstanding the benefits and risks of procedures requiring informed consent.
- The JCAHO and the National Committee for Quality Assurance (NCQA) should incorporate standards for measuring systemic cultural competence.
- Government programs (e.g., Medicare and Medicaid), recipients of federal funding (e.g., hospitals), and private organizations (e.g., managed care plans) should collect data on race, ethnicity, and language preference^g for all beneficiaries, members, and clinical encounters to facilitate the monitoring of disparities, the reporting of quality data, and the implementation of initiatives to improve care.

CLINICAL CULTURAL COMPETENCE

- Cross-cultural training should be a required, integrated component of the training and professional development of health care providers at all levels. The curricula should:
 - > increase awareness of racial and ethnic disparities in health and the importance of sociocultural factors on health beliefs and behaviors;

^g This report endorses the more detailed recommendations of the Commonwealth Fund report, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (New York: The Commonwealth Fund, September 2001). It is on the Internet at www.cmwf.org.

- > identify the impact of race, ethnicity, culture, and class on clinical decision-making;
 - > develop tools to assess the community members' health beliefs and behaviors; and
 - > develop human resource skills for cross-cultural assessment, communication, and negotiation.
- Quality improvement efforts should include culturally and linguistically appropriate patient survey methods as well as process and outcome measures that reflect the needs of multicultural and minority populations.^h
 - Programs should be developed to help patients navigate the health care system and become a more active partner in the clinical encounter.

^h This report endorses the work reported in David Nerenz et al., *Developing a Health Plan Report Card on Quality of Care for Minority Populations* (New York: The Commonwealth Fund, July 2002).

APPENDIX I. METHODOLOGY

Research for this project included a review of the literature on health disparities and cultural competence, interviews with experts in the field, and site visits.

LITERATURE REVIEW

We focused on two areas in the literature review: racial/ethnic disparities in health care and cultural competence. We identified studies that document racial/ethnic disparities in health care due to sociocultural barriers among patients, providers, and the health care system. We also researched articles on culturally competent approaches to addressing sociocultural barriers to health care.

We included in our final review only those publications that specifically identified sociocultural barriers contributing to racial/ethnic disparities and those on cultural competence interventions and strategies.

INTERVIEWS WITH EXPERTS

We selected experts who had presented at one of a series of national meetings on the topicⁱ or who were members of national expert cultural competence advisory panels.^j We also employed snowball sampling using sequential recommendations from initial key informants.

We asked the experts to define cultural competence in their domain of health care, identify key actionable components of cultural competence, describe leverage points for action and implementation, identify links to racial/ethnic disparities in health care, and suggest models of culturally competent care.

We conducted a total of 37 interviews with representatives from academia, government, managed care, and community health care (35 conducted via telephone, two conducted in person) (Appendix II).

ⁱ National Conference on Quality Health Care to Culturally Diverse Populations, The New York Academy of Medicine, October 1998; Providing Care to Diverse Populations: State Strategies for Promoting Cultural Competency in Health Systems, Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) User Liaison Program, June 1999; Difference Matters: Multiculturalism in Medical Education, Harvard Medical School, June 1999; Kaiser Family Foundation's Conference, "Race, Ethnicity, and Medical Care: Improving Access in a Diverse Society," October 1999.

^j Health Care Financing Administration Quality Improvement Standards in Managed Care Cultural Competence Quality Measure Review Panel; Association of American Medical Colleges Diversity Project Team, Office of Minority Health Culturally and Linguistically Appropriate Services Project Advisory Group, New York Academy of Medicine Working Group on Racial/Ethnic Disparities.

SITE VISITS

We selected models of culturally competent care based on recommendations from experts using these criteria:

1. The academia model had implemented a formal cross-cultural curriculum with an evaluation component.
2. The government model had implemented a cultural competence intervention and/or policy at the federal or state level with an evaluation component that included cost and quality.
3. The managed care and community health models had implemented cultural competence interventions with evaluation components.

We visited each of the four model practices for one-half day to assess the nature and history, development, supports and challenges, structure, process, and measured impact of the cultural competence interventions.

APPENDIX II. KEY INFORMANTS

Academia	Government	Managed Care	Community
Robert Like, M.D., M.S. Associate Professor of Family Medicine Robert Wood Johnson Medical School Newark, NJ	Len Epstein Senior Advisor on Quality and Culture The Quality Center Bureau of Primary Health Care Health Services Resource Administration	Gayle Tang, R.N., M.S.N. Director National Linguistic and Cultural Programs Kaiser Permanente	Christy Swanson Washington Free Clinic Washington, D.C.
Melanie Tervalon Co-Chair, Culture and Behavior in the Curriculum University of California, San Francisco	Denice Cora-Bramble, M.D. Director Quality Center Bureau of Primary Health Care Bethesda, MD	John O'Brien, M.B.A. CEO Cambridge Health Alliance	Maria Fernandez South L.A. Health Projects Los Angeles, CA
Ron Garcia, Ph.D. Asst. Dean of Minority Affairs Stanford Medical School Palo Alto, CA	Julia Puebla-Fortier Director Resources for Cross Cultural Health Care Silver Springs, MD	Beau Stubblefield-Tave, M.B.A. Health Policy Consultant	Sherlyn Dahl, R.N., M.P.H. Executive Director Family Health Care Center Fargo, ND
Tom Delbanco, M.D. Professor of Medicine Harvard Medical School Beth Israel Deaconess Hospital Boston, MA	Tom Perez, J.D. Director Office of Civil Rights Washington, DC	Kathryn Linde, M.P.H. Blue-Cross/Blue-Shield of Minnesota	Merle Cunningham, M.D., M.P.H. Medical Director Lutheran Medical Center, Brooklyn, NY
Lisa Cooper-Patrick, M.D., M.P.H. Assistant Professor of Medicine and Health Policy Johns Hopkins University Baltimore, M.D.	Guadelupe Pacheco Project Officer Office of Minority Health Washington, DC	David Nerenz, Ph.D. Director, Institute for Health Care Studies, Michigan State University	Molly McNees, M.A. Medical Anthropologist Lutheran Medical Center Brooklyn, NY
Kathleen Culhane-Pera, M.D., M.A. Department of Family Practice University of Minnesota	Valerie Welsh Project Officer Office of Minority Health Washington, DC		
Luis F. Guevara, Psy.D. Manager of Cross Cultural Training White Memorial Medical Center Los Angeles, CA	Miya Iwataki Director Diversity Programs Los Angeles County Department of Health		

Academia	Government	Managed Care	Community
Ana Nunez, M.D. Director Women's Health Education Program MCP-Hahnemann Philadelphia, PA	Bonnie Jacques, M.S.W. Chief Office of Administrative Resources Washington State Department of Social and Health Services		
Robert Putsch, M.D. Professor of Medicine, University of Washington Cross Cultural Health Care Program Seattle, WA	Melba Hinojosa, M.A., R.N. Health Plan Advisor, MediCal Managed Care California Department of Health		
Melissa Welch, M.D., M.P.H. Division of General Internal Medicine University of California, San Francisco	Dennis Andrulis, Ph.D. Department of Medicine State University of New York–Downstate		
Deborah Danoff, M.D. Vice President, Division of Medical Education Association of Academic Medical Centers Washington, DC	Iris Garcia, Ph.D. Health Policy Analyst Division of Medical Assistance, Office of Clinical Affairs		
Karen Cole, Sc.D. Assistant Professor of Medicine Johns Hopkins Baltimore, MD	Michael Katz Centers for Medicare and Medicaid Services		
Ed Christian, M.D. Thomas Jefferson University Philadelphia, PA	Tawara Goode Associate Director Community Planning, Center for Child and Human Development Georgetown University Washington, DC		
Charles Aswad Council on Graduate Medical Education			

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#547 *A Health Plan Report Card on Quality of Care for Minority Populations* (June 2002). David R. Nerenz, Margaret J. Gunter, Magda Garcia, and Robbya R. Green-Weir. In this study, eight health plans participated in a demonstration project designed to determine whether health plans could obtain data on race/ethnicity of their members from a variety of sources and incorporate those data in standard quality of care measure sets, and whether the analyses would show significant racial/ethnic disparities in quality of care within plans, and/or significant differences across plans in quality of care provided to specific groups.

Addressing Racial and Ethnic Barriers to Effective Health Care: The Need for Better Data (May/June 2002). Arlene S. Bierman, Nicole Lurie, Karen Scott Collins, and John M. Eisenberg, *Health Affairs*, vol. 21, no. 3. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#557 *Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?* (May/June 2002). David R. Nerenz, Vence L. Bonham, Robbya Green-Weir, Christine Joseph, and Margaret Gunter. *Health Affairs*, vol. 21, no. 3. The absence of data on race and ethnicity in health plan and provider databases is a significant barrier in the creation and use of quality-of-care reports for patients of minority groups. In this article, however, the authors show that health plans are able to collect and analyze quality of care data by race/ethnicity.

#541 *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* (May 2002). Mara Youdelman and Jane Perkins, National Health Law Program. This report profiles a variety of promising programs around the country that provide patients with interpretation services, and also identifies federal, state, local, and private funding sources for such services.

#523 *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (March 2002). Karen Scott Collins, Dora L. Hughes, Michelle M. Doty, Brett L. Ives, Jennifer N. Edwards, and Katie Tenney. This report, based on the Fund's 2001 Health Care Quality Survey, reveals that on a wide range of health care quality measures—including effective patient-physician communication, overcoming cultural and linguistic barriers, and access to health care and insurance coverage—minority Americans do not fare as well as whites.

#524 *Quality of Health Care for African Americans* (March 2002). Karen Scott Collins, Katie Tenney, and Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of African Americans.

#525 *Quality of Health Care for Asian Americans* (March 2002). Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Asian Americans.

#526 *Quality of Health Care for Hispanic Populations* (March 2002). Michelle M. Doty and Brett L. Ives. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Hispanics.

#532 *Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care* (March 13, 2002). Eric C. Schneider, Alan M. Zaslavsky, and Arnold M. Epstein, Harvard School of Public Health/Harvard Medical School. *Journal of the American Medical Association*, vol. 287, no. 10. In this article the authors report that among Medicare beneficiaries enrolled in managed care plans, African Americans are less likely than whites to receive follow-up care after a hospitalization for mental illness, eye exams if they are diabetic, beta-blocker medication after a heart attack, and breast cancer screening.

#492 *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (September 2001). Ruth T. Perot and Mara Youdelman. Using interviews conducted with administrators at federal health agencies, this report finds wide gaps between the goals of federal initiatives to eliminate racial and ethnic disparities in health care—such as Healthy People 2010—and the efforts of federal health agencies to collect and report data needed to help achieve these goals. The report provides the first comprehensive analysis of the policies and statutes governing the collection of health care data by race, ethnicity, and primary language.

Are Urban Safety Net Hospitals Losing Low-Risk Medicaid Maternity Patients? (April 2001). Darrell J. Gaskin, Jack Hadley, and Victor G. Freeman. *HSR: Health Services Research*, vol. 36, no. 1, part 1. Copies are available from *HSR: Health Services Research*, Foundation of the American College of Healthcare Executives, Publication Services, One North Franklin, Suite 1700, Chicago, IL 60606-3491, Fax: 312-424-0703.

Addressing Racial Disparities in Health Care Delivery: A Regional Response to the Problem (January 2001). Alan R. Fleischman and Emily B. Wood, New York Academy of Medicine. Copies are available from the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029, Tel: 212-822-7222, E-mail: ewood@nyam.org.

Vulnerable Populations and Medicare Services: Why Do Disparities Exist? (2000). Marian E. Gornick. Copies are available from Century Foundation Press, The Brookings Institution, 1775 Massachusetts Avenue, NW, Washington, DC 20036, Phone: 800-552-5450, Fax: 202-797-6004, www.tcf.org.

Minority Health in America (2000). Carol J. Rowland Hogue, Martha A. Hargraves, and Karen Scott Collins (eds.). This book reviews findings from The Commonwealth Fund's 1994 National Comparative Survey of Minority Health Care, providing the documentation needed to assess the successes and failures of the current system with regard to minority health care and to chart productive directions for the future. Copies are available from the Johns Hopkins University Press, 2715 North Charles Street, Baltimore, MD 21218-4363, Tel: 410-516-6900, Fax: 410-516-6968, E-mail: www.press.jhu.edu.

#351 *The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs* (November 1999). Lynne Fagnani and Jennifer Tolbert, National Association of Public Hospitals and Health Systems. As the federal government begins reducing subsidies for safety net hospitals, the authors detail the reliance of safety net hospitals—which treat all patients regardless of their ability to pay—on the Medicare and Medicaid disproportionate share hospital payment programs.

Experiences of Minority Primary Care Physicians with Managed Care: A National Survey (October 1999). Elizabeth R. Mackenzie, Lynne S. Taylor, and Risa Lavizzo-Mourey. *American Journal of Managed Care*, vol. 5, no. 10. From their analysis of a national survey of primary care physicians, the authors determine that differences in rates of termination, type of practice, board certification rates, and managed care affiliation are related to physician ethnicity. Copies are available from Elizabeth Mackenzie, Division of Geriatric Medicine, University of Pennsylvania Health System, 5 Maloney, 3400 Spruce Street, Philadelphia, PA 19104-4283, E-mail: emackenz@mail.med.upenn.edu.

Population Characteristics of Markets of Safety Net and Non-Safety Net Hospitals (September 1999). Darrell J. Gaskin and Jack Hadley. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 76, no. 3. This article reports that urban safety net hospitals disproportionately serve minority and low-income communities that otherwise face financial and cultural barriers to health care. Copies are available from the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029-5293.

Race, Gender, and Partnership in the Patient-Physician Relationship (August 11, 1999). Lisa Cooper-Patrick, Joseph J. Gallo, Junius J. Gonzales, Hong Thi Vu, Neil R. Powe, Christine Nelson, and Daniel E. Ford. *Journal of the American Medical Association*, vol. 282, no. 6. Copies are available from Genuine Article/Institute for Scientific Information, 3501 Market Street, Philadelphia, PA 19104, Phone: 1-800-336-4474 option 5, Fax: 215-386-4343, E-mail: ids@ininet.com.

#321 *U.S. Minority Health: A Chartbook* (May 1999). Karen Scott Collins, Allyson Hall, and Charlotte Neuhaus. This chartbook, which is intended to serve as a quick reference for currently available information on minority health, shows that minorities continue to lag behind whites on many important health indicators, including infant mortality rates, life expectancy, and health insurance coverage.

#300 *Community Health Centers in a Changing U.S. Health Care System* (May 1999). Karen Davis, Karen Scott Collins, and Allyson G. Hall. In this policy brief, the authors discuss how major changes in the health care system—the growth of managed care and an increasingly for-profit health care sector—affect the delivery of health services provided by community health centers. These centers have played a critical role in serving some of the most vulnerable populations for more than 30 years.

#311 *Medicaid Managed Care and Cultural Diversity in California* (March 1999). Molly Coye and Deborah Alvarez, the Lewin Group. The authors examine the effect of cultural competence contract provisions that were enacted in 1993 by Medi-Cal, California's Medicaid program. Analysis finds early promise in improving access to and understanding of health care services for low-income, non-English-speaking minority enrollees.

#314 *Employer-Sponsored Health Insurance: Implications for Minority Workers* (February 1999). Allyson Hall, Karen Scott Collins, and Sherry Glied. This report shows that disparities in minorities' health insurance coverage can be found across industries, occupations, and part- and full-time workers, and that no matter what the company size, minority workers are less likely to receive health insurance from their employer.

#309 *Safety Net Hospitals: Essential Providers of Public Health and Specialty Services* (February 1999). Darrell J. Gaskin, Georgetown University. This study attempts to identify the public health and specialty services that are provided primarily by safety net hospitals and determine whether communities rely on these hospitals for such services.