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PHYSICIANS' PERCEPTIONS OF CULTURAL COMPETENCE IN HEALTH CARE

By

Andrea L. Abercrombie

A doctoral project
Submitted to the faculty
Of
The Medical University of South Carolina
In partial fulfillment of the requirements
For the degree
Doctor of Health Administration
In
The College of Health Professions

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Dedication

To my Grandmother, Lily Abercrombie; my parents, Sara and Richard Abercrombie; my siblings, James and Anita Abercrombie; my nephews, Christopher and Alexander Abercrombie; my son, Khalil Ulmer; and *Everyone* who demonstrated their love, encouragement, and support – I thank you.

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Approved by:

Chair, Project Committee	James Zoller, PhD	7/20/15 Date
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Abstract of Doctoral Project Report
Presented to the Executive Doctoral Program in Health Administration and Leadership
Medical University of South Carolina
In Partial Fulfillment of the Requirements
For the Degree of
Doctor of Health Administration

PHYSICIANS' PERCEPTIONS OF CULTURAL COMPETENCE IN HEALTH CARE

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Chairperson: James Zoller, PhD
Committee: David Graber, PhD
Kinneil Coltman, DHA

Health care disparities continue to impact racial and ethnic minorities in the United States. These disparities may become even more predominant as the population of immigrants and racial and ethnic minorities increases in the country. Health care policymakers, administrators, accreditation bodies, and academia support the practice of cultural competence as a strategy to reduce both health and health care disparities among racial and ethnic minority populations. Yet, although cultural competence strategies have been developed and supported, they are often not implemented by physicians. Researchers need to explore physicians' perspectives of cultural competence in order to increase physician engagement and inform academia, policymakers, accrediting bodies, and administrators as to ways to increase physician "buy-in" and improve cultural competence in health care.

Keywords: disparities, cultural competence, minority, physician, health care

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CHAPTER 1

Introduction

Background and Need

Health and Health Care Disparities Experienced by Racial and Ethnic Minorities

It is well documented in the United States (U.S.) that racial and ethnic minorities persistently experience disparities in both health and health care (Andrulis, Siddiqui, Purtle, & Duchon, 2010). Whereas racial and ethnic health disparities manifest as a result of differences in health indicators such as lower life expectancy, higher infant mortality, and higher incidence and prevalence of chronic diseases (Andrulis et al., 2010), racial and ethnic health care disparities present as a result of differences in the delivery of health care. Although health disparities among racial and ethnic minorities are often attributed to issues of poor access to health care systems, studies indicate that even when controlling for health care access factors such as transportation, insurance coverage, and income status, “disparities in the health care system contribute to the overall disparities in health status that affect racial and ethnic minorities” (American College of Physicians [ACP], 2010, p. 3). Sources of health care disparities in the health care system have been ascribed to communication obstacles, cultural barriers, and provider influences such as racial and ethnic biases, stereotyping, and prejudices (ACP, 2010). In fact, research studies demonstrate that the race and ethnicity of patients influence both providers’

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feelings about patients and providers' diagnostic decisions (American College of Physicians [ACP], 2004). In spite of efforts to reduce disparities, they continue to exist (Green, Betancourt, Park, Greer, Donahue, & Weissman, 2008) and researchers continue to search for ways to reduce them through the enhancement of the quality of care provided to these populations.

United States Projected Population Changes

Immigrants and Racial and Ethnic Minorities

Without effectively addressing and eliminating health and health care disparities among racial and ethnic populations in the U.S., the prevalence of these disparities will become exacerbated as the population of racial and ethnic minorities continues to grow and to challenge health care providers as they attempt to provide quality care for all (De Maesschalck, Willems, & De Maeseneer, 2010). Current U.S. population trends suggest that the U.S. population will grow from a reported 296 million people in 2005 to an anticipated 438 million people by the year 2050 (Passel & Cohn, 2008); it is expected that 82% of this increase will be due to the arrival of new immigrants and their descendants (Passel & Cohn, 2008). Population trends also indicate that racial and ethnic minorities will increase from a reported 35.1% of the population in 2010 to a projected 53.6% of the population in the year 2050 (The Henry J. Kaiser Family Foundation [KFF], 2010). In preparation for the realization of these projections, it is imperative that health care systems and providers improve upon their abilities to provide quality health care to an increasingly diverse nation.

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Limited English Proficient Individuals

By the year 2050, it is expected that approximately one in five U.S. residents will be immigrants (Passel & Cohn, 2008). As the number of immigrants to the U.S. increases, the number of limited English proficient (LEP) residents will increase as well. In 2009, it was reported that 57.1 million people (20% of the U.S. population age 5 and older) spoke a language other than English at home (Shin, 2011). Language projection models indicate that this number is expected to increase somewhere between an additional 9.2 million to 14.7 million people by the year 2020 (Shin, 2011). Among immigrant populations, those who are not fluent in English often receive poorer quality care when compared to those who are (Youdelman, 2008). The necessity for health care systems to effectively address the communication needs of LEP populations becomes more evident when one learns that national studies report that 43% of hospitals and 84% of federally qualified health centers provide care for LEP patients on a daily basis, and 20% of hospitals and 54% of internal medicine physicians treat LEP patients on at least a weekly basis (Hasnain-Wynia, Yonek, Pierce, Kang, & Greising, 2006; Barrett, Dyer, & Westpheling, 2008). Discovering ways to decrease health and health care disparities and enhance the quality of care for this population is of great importance since errors in communication are known to frequently be the root cause of medical errors (Woolf, Kuzel, Dovey, & Phillips, 2004).

Addressing Health Care Disparities through Cultural Competence

Health care policymakers realize that failing to address sociocultural differences between providers and patients can thwart communication, lead to patient dissatisfaction, negatively impact compliance with treatment plans, and lead to poor health outcomes

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(Kim, Kaplowitz, & Johnston, 2004; Zolnierek & DiMatteo, 2009; Riess, 2010; Neumann et al., 2011). A review of the literature reveals that cultural competence is viewed by health care policymakers, providers, insurers, and educators as a quality improvement strategy with the potential to eliminate racial and ethnic disparities in health care (Betancourt, Green, Carrillo, & Park, 2005). One example of support for cultural competence comes from the American College of Physicians (2010), the nation's largest medical specialty society, which writes, "Culturally competent care ensures that all patients receive high-quality, effective care irrespective of cultural background, language proficiency, economic status, and other factors that may be informed by a patient's race or ethnicity" (p. 7). Another example of support comes from the U.S. Department of Health and Human Services (2011) which states, "The ability of the healthcare workforce to address disparities will depend on its future cultural competence and diversity" (p. 3). It is also worth noting that the Liaison Committee on Medical Education (LCME) requires that all medical schools include cultural competence as part of their curricula, and the Accreditation Council for Graduate Medical Education (ACGME) includes cultural competence standards as part of its accreditation processes (Betancourt et al., 2005).

Issues Surrounding Cultural Competence

Education

Despite the adoption of cultural competence standards in medical schools and health care systems, many of these standards are not met when physicians deliver care to racially and ethnically diverse populations (De Maesschalck et al., 2010). Although the reasons for these failures in execution remain unknown, some claim that issues with

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execution are linked back to failures in the process of teaching cultural competence during medical school. For instance, one study suggests that it is difficult to teach cultural competence in medical schools due, in part, to medical students' preexisting attitudes about the subject and tendencies for some students to deny or minimize cultural influences on medicine (Boutin-Foster, Foster, & Konopasek, 2008). Another study found that some medical students were not interested in learning about culturally competent health care because they viewed it as a soft science (Kai, Bridgewater, & Spencer, 2001). Additional studies will need to be performed in order to inform medical school educators of methods which can be employed to effectively engage medical students in cultural competence education and increase the application of cultural competence in health care.

Gaps in the Literature

Efficacy.

Although a review of the literature establishes the practice of cultural competence as an effective strategy for reducing health and health care disparities, more studies are needed to verify the efficacy of cultural competence training and the accuracy of such claims. Whereas evidence demonstrates that training in cultural competence improves physicians' attitudes, knowledge, and skills (Crandall, George, Marion, & Davis, 2003), there is little empirical evidence to link such training and improvements to actual behavioral changes among clinicians, improved health outcomes, or reductions in health and health care disparities (Crandall, et al., 2003; Betancourt & Green, 2010; Brach & Fraserirector, 2000). Although instruments exist to validate the effectiveness of aspects

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of cultural competence, some claim that these measures are insufficient. As one study reports:

> Existing measures embed highly problematic assumptions about what constitutes cultural competence. They ignore the power relations of social inequality and assume that individual knowledge and self-confidence are sufficient for change. Developing measures that assess cultural humility and/or assess actual practice are needed if educators in the health professions and health professionals are to move forward in efforts to understand, teach, practice, and evaluate cultural competence. (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007)

Physicians' Perspectives.

Because physicians play a primary role in the delivery of culturally competent health care, it is important to gain the perspectives of practicing physicians in order to understand more about its applications, implications, and practice challenges; nevertheless, little is found in the literature to explore physicians' perspectives of what cultural competence means to them. Studies have explored physicians' perceptions of health care disparities (Wilson, Grumbach, Huebner, Agrawal, & Bindman, 2004); examined cultural competence by ascertaining perspectives from managed care, academe, and government (Betancourt, Green, Carrillo, & Park, 2005); measured physicians' attitudes towards providing cross-cultural care (Weissman et al., 2005) – to include treating ethnic minority patients (De Maesschalck et al., 2010) and caring for immigrant patients (Hudelson, Perron, & Perneger, 2010); studied the relationship between personal traits and resident physicians' self-perceived preparedness to deliver culturally competent care (Lopez, Vranceanu, Cohen, Betancourt, & Weissman, 2008); measured resident's

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preparation and skill to deliver cross-cultural care (Paez, Chun, Betancourt, Green, & Weissman, 2009); and captured patient ratings of the patient-physician relationship as associated with physician's self-reported cultural competence (Paez, Allen, Beach, Carson, & Cooper, 2009). Although these studies have made significant contributions to the practice of health care, the literature contains a gap which, if closed, may prove to be beneficial to policymakers, educators, patients, providers, and health care systems for its potential to increase understanding of the influences which may impact the delivery of culturally competent care to racially and ethnically diverse patient populations. Feedback from J. R. Betancourt, M.D (personal communication, November 26, 2012) – Associate Professor of Medicine at the Harvard Medical School, Co-chair of the Harvard Medical School Cross-Cultural Care Committee, and investigator of numerous studies on cultural competence (and related subjects) – affirms that providers' perspectives of cultural competence is an area which needs further exploration.

Problem Statement

Health care systems that provide services in a culturally competent manner "…have the potential to reduce racial and ethnic health disparities" (Anderson et al., 2003). This notwithstanding, the efficacy of cultural competence is dependent upon physician support and buy-in (Betancourt and Green, 2010). By gaining a better understanding of physicians' perspectives and insights about cultural competence, health care systems can use this understanding to enhance physician buy-in and improve upon the delivery of culturally competent care. Examining physicians' perspectives of cultural competence is important for its ability to inform academia and policymakers since physicians' attitudes influence medical school cultural competence and health policy

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curricula changes (Paez et al., 2009; Wilson et al., 2004). This exploration is an important step toward ensuring the success of cultural competence policies, training, education, and practices and potentially reducing health and health care disparities – the overarching goal of cultural competence in health care.

Research Questions

This study explores physicians' perspectives of cultural competence. This investigation will be guided by the use of research questions in lieu of research hypotheses since, in exploratory studies, "the researcher does not . . . make assumptions about the interrelationships among . . . data prior to making . . . observations" (Rudestam & Newton, 2007, p. 37), and the formulation of research hypotheses would require that current knowledge indicates ". . . anticipated directions of the relationships among the variables of interest" (Shi, 2008, p. 54).

With this in mind, the primary research questions guiding this study are:

1. What are physicians' perspectives around the importance of the practice of cultural competence in health care?
2. Do physicians perceive that cultural competence is practiced in health care?
3. What perspectives do physicians have regarding ways to increase physician engagement in culturally competent practices in health care?
4. What attitudes do physicians perceive as paramount to effectively practice cultural competence in health care?
5. What skills do physicians perceive as paramount to effectively practice cultural competence in health care?

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Study Participants

Study participants consist of female and male primary care practicing physicians of diverse racial, ethnic and linguistic backgrounds. Participants are associated with various practice settings in South and North Carolina. Study participants vary in age and years of medical practice.

Definition of Terms

Culture

Culture is generally defined in the literature as "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (Boutin-Foster et al., 2008, p. 108).

Cultural Competence in Health Care

Although definitions of cultural competence differ somewhat, in general, the concepts which they express are the same. In the health care literature, cultural competence is defined as "…a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations" (Anderson, et al., 2003, p. 68). It is also defined as "…the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds…" (Betancourt & Green, 2010, p. 583) to include religion, sexual orientation, race, gender, ethnicity, and country of origin. These definitions assume "the ability of individuals to establish effective interpersonal working relationships that supersede cultural differences" (Cooper & Roter, 2003, p. 554) and "the ability of health care providers and health care organizations to

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understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter" (The Joint Commission [TJC], 2010, p. 1). In keeping with these considerations of cultural competence, educating and training physicians in cultural competence is intended to:

> Increase physician awareness of health-care disparities and their attitudes contributing to disparities, increase knowledge of health-care issues unique to minority populations and increase behaviors that will enhance physicians' ability to build rapport, communicate effectively with patients who culturally differ and develop a plan of care acceptable to the patient. (Paez et al., p. 495)

Given these understandings of cultural competence, for health care organizations and personnel to be considered culturally competent, it would require that they do the following: "(1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served" (TJC, 2010, p.1). Having common definitions and understandings of cultural competence will assist researchers, academia, and policymakers as they continue to explore cultural competence in health care.

Health Care

In the context of this project, health care is defined as the delivery of health care services.

Primary Care Physician

For the purposes of this study, primary care physician is defined as a physician practicing medicine in one of the following four areas:

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- Family medicine/general medicine
- Internal medicine
- Pediatric medicine
- Obstetric/gynecological medicine

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CHAPTER 2

Review of the Literature

The Nature, Goal, and Structure of the Literature Review

Shi (2008) describes four independent types of reviews: the theoretical review – a summary of all existing relevant theories, on a particular topic, with the aim of refining those theories; the methodological review – a summary of the different designs used to explore a particular topic with the aim of examining the efficacy of the use of the various designs; the integrative review – a summary of past studies with the aim of presenting the state of knowledge of a particular topic; and the policy-oriented review – a summary of the current knowledge of a topic with the aim of using the study findings to construe policy implications. This literature review is a combination of an integrated and policy-oriented review. This combination is deemed most apropos for (a) its ability to inform the reader of the current state of knowledge related to culturally competent health care and (b) its propensity to inform cultural competence policymakers and curricula developers of the policy and curricula implications which may be drawn from the results of the study.

In addition to the integrative and policy-oriented focus of this review, the format and composition of this literature review takes into consideration the inductive and open nature of a phenomenological (or descriptive) qualitative study describing physicians' perspectives of cultural competence. To accomplish the goals of a qualitative literature

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review, the review orients the reader to the existing literature and relevant empirical studies, while, at the same time, guarding against an "…overly comprehensive or overly focused review [which] preempts the researcher from greeting his or her data with the appropriate level of openness, curiosity, and wonder" needed to conduct a qualitative study (Rudestam & Newton, 2007, p. 71). In keeping with qualitative literature reviews, on the one hand, this review is not intended to be overly comprehensive or focused, but on the other hand, it is meant to have a "…narrow scope…restricted to those studies pertinent to the specific issue addressed by the primary research" (Shi, 2008, p. 107).

Although cultural competence is intended to improve the health status and to reduce the health and health care disparities affecting minority populations, this literature review is focused specifically on cultural competence as a potential strategy to reduce these disparities; the review is not focused on the disparities themselves. As mentioned in the introductory section of this paper, disparities in both health and health care are well documented (Andrulis et al., 2010) and, while disparities are mentioned in the review, it is not the goal of this literature review to explore such a comprehensively studied and documented topic. As such, disparities are not addressed in this review with any depth. Likewise, although disparities in health may also be attributed to patient and societal factors (such as a lack of compliance with treatment plans, genetic predispositions, and access to health care services), this review does not address patient behaviors, health status, or societal conditions which may lead to disparate health and/or disparate care.

The goal of this review is to explore cultural competence in such a way as to assist the reader in making the determination that the study is indeed a timely and suitable study to both contribute to the status of knowledge in the field of cultural competence and

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to inform cultural competence policy and curricula. As such, this review is intended to demonstrate the need to study physicians' perspectives of the provision of culturally competent health care. To accomplish the goal of this review, the literature review is structured in such a way as to:

1. describe the need for cultural competence in health care;
2. inform the reader of the timeliness of the study by highlighting cultural competence laws, initiatives and/or policy positions from government, health care and medical education accrediting bodies, medical and physician organizations and associations, academic medicine, and public health;
3. apprise the reader of the status of reliable knowledge in the field of cultural competence by delimiting and critiquing previously conducted relevant studies; and
4. demonstrate the appropriateness of the study

The Need for Cultural Competence in Health Care

Federal Identification of the Need to Reduce Health Disparities

One of the nation's first known attempts to implement strategies to eradicate health disparities was initiated in 1984 by Margaret M. Heckler, former Secretary of the U.S. Department of Health and Human Services (HHS), who noted that disparities in health among racial and ethnic minorities have "…existed ever since accurate federal record keeping began…" (U.S. Department of Health and Human Services [HHS], 1985, p. ix). The former HHS Secretary described these disparities as "…an affront both to our ideals and to the ongoing genius of American medicine" (HHS, 1985, p. ix). In an effort to learn more about the causes of these disparities, in January of 1984, Secretary Heckler

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established a Secretarial Task Force on Black and Minority Health and assigned its members the responsibility of comprehensively investigating the health issues which plagued racial and ethnic minority groups in the U.S. In addition to this charge, the task force was responsible for finding ways to close the existing gap in the health of racial and ethnic minorities. Regarding the work of the task force, Secretary Heckler stated, "It can—it should—mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health" (HHS, 1985, p. ix). This attempt marks one of the first efforts to specifically address and target the health needs of racial and ethnic minority populations in the United States (to view a copy of the original *HHS Secretary's Foreword and Charge to the Task Force on Black and Minority Health*, see Appendix A).

In more recent history, federal attempts to reduce health and health care disparities were enacted into law on November 22 of 2000. On this date, the U.S. 106th Congress amended the Public Health Service Act in an attempt to improve the health of racial and ethnic minorities. In brief, this amendment, Public Law 106-525, the *Minority Health and Health Disparities Research and Education Act of 2000*:

- mandates the establishment of a National Center on Minority Health and Health Disparities,
- requires research on health disparities by the Agency for Healthcare Research Quality,
- necessitates that the National Academy of Sciences conduct a study on data collection practices related to race and ethnicity,

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- decrees that health care professionals receive education on health disparities, and
- orders that the public be made aware of health disparities through the dissemination of information (Minority Health and Health Disparities Research and Education Act, 2000).

To view this amendment's titles and section descriptions, see Appendix B.

Cultural Competence as a Disparity-Reduction Strategy

In 2003, the Institute of Medicine's (IOM) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care produced a report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. In this report, the IOM (2003) recommends that all health care professionals receive cross-cultural communication training in an effort to address racial and ethnic disparities in health care. This recommendation arose from evidence which suggested that patient satisfaction, trust, communication, adherence to treatment plans, and health outcomes are negatively impacted when health care providers fail to understand, acknowledge, respect, and manage variations in the health beliefs and practices of patients (IOM, 2003). In support of the IOM (2003) findings, the American Medical Association (AMA) and the American College of Physicians (ACP) developed policy position papers asserting that cultural competence is necessary to effectively practice medicine (Betancourt & Green, 2010). Presently, in order to receive accreditation, medical schools and residency programs must provide cultural competence education. In some states, this requirement is also applicable to continuing medical education units and medical licensure (Betancourt & Green, 2010).

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Because of reports like *The Report of the Secretary's Task Force on Black and Minority Health*, the IOM's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, and others, health care policymakers now realize that failing to address sociocultural differences between providers and patients can thwart communication, lead to patient dissatisfaction, negatively impact adherence to treatment plans, and, ultimately, lead to poor health outcomes (Kim et al., 2004; Zolnierek & DiMatteo, 2009; Riess, 2010; & Neumann et al., 2011). Without policies in place to encourage and provide guidance for culturally competent care, providers may remain uninformed of and misunderstand cultural components affecting patient care. This misunderstanding, in turn, may lead to unintended health consequences for patients (Green et al., 2008). As examples, a lack of knowledge about the prevalence of certain conditions which disproportionately affect specific minority groups may lead to missed medical screening opportunities, and a lack of awareness about the use of traditional remedies by certain cultural groups may lead to harmful drug interactions if this information is not taken into account when providers prescribe Western medicinal therapies (ACP, 2004). Physicians must be educated about the potential cultural differences which may exist among patients if they are to positively impact the quality of care and satisfaction of diverse patient populations.

In recent years, concerns about cultural competence have increased as policymakers and providers strive to eradicate racial and ethnic health disparities which continue to exist in spite of efforts to reduce them (Green et al., 2008). Not only is it clear that disparities exist in the health *status* between minority and majority populations, but, as Betancourt (2006) states, "in addition to the existence of racial and ethnic

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disparities in health, there is also evidence of racial and ethnic disparities in health *care*" (p. 788). Examples of disparities in *care* are evident when, compared to their White counterparts with similar health issues, African-Americans are referred less for cardiac catheterization, prescribed less pain medication, receive less surgery for lung cancer, and are referred less to renal transplant lists (Betancourt, 2006). Further studies are needed to examine the root causes of these disparities in care and to develop policies, educational programs, and protocols to eliminate them.

Research demonstrates that patients' race and ethnicity influence not only providers' feelings about patients but also providers' diagnostic decisions (ACP, 2004). Cultural competence policies facilitate the means by which providers may become aware of any biases and stereotypes which they may have toward patient populations and enhance providers' efforts to understand how these biases and stereotypes may influence their actions and decisions when providing patient care (ACP, 2004). By encouraging providers to focus on their interactions with culturally diverse patient populations, cultural competence policies will not only assist practitioners with recognizing potential health care disparities and practices affecting specific cultural groups, but will also have the potential to positively impact health care outcomes by minimizing bias-influenced health care decisions.

In the past, cultural competence education focused on a "categorical approach" to culture. This approach taught health care professionals about attitudes, beliefs, values and behaviors which have been associated with specific racial and ethnic cultural groups as a whole (Betancourt & Green, 2010). Over time, however, this approach evolved as it became evident that culture varied both between and within cultural groups. Presently,

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the categorical approach is considered to be an overly simplified and antiquated approach to cultural competence, and it is thought to lend itself to the overgeneralization of cultural dynamics which, in turn, leads to stereotyping and minimizing the cultural complexities and differences related to individuals within the same cultural group (Betancourt & Green, 2010). Whereas past cultural competence curricula focused on stereotypical, categorical constructs of cultural values, beliefs, and customs, more recent curricula acknowledge the value of "…developing important skills and attitudes in clinicians" (Hyun, 2008, p. 155). The development of culturally competent attitudes and skills sets the foundation by which health care practitioners may assess the sociocultural factors which may affect patient care for an individual patient (Betancourt & Green, 2010). In this sense, today's cultural competence policies are essentially patient-centered care policies which take into consideration sociocultural dimensions which may impact the nature of the provider-patient relationship, treatment plans, and, ultimately health care outcomes. As stated by the Association of American Medical Colleges (2005), "Cultural competence in health care combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services and treatment" (p. 1).

The Key Principles of Cultural Competence

In the Introduction chapter, cultural competence is defined as the "…ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds…" (Betancourt & Green, 2010, p. 583). Although aspects of these diverse sociocultural backgrounds are numerous and can include, but are not limited to, religion, sexual orientation, race, gender, ethnicity, and

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country of origin (Betancourt & Green, 2010), traditionally, the literature has predominantly centered on health and health care disparities affecting racial and ethnic minorities. Likewise, just as there are many facets of diversity, there also exists a plethora of cultural competence techniques which can be employed to provide culturally competent and quality health care. Some of these techniques, for example, include "…the use of interpreter services, racially or linguistically concordant clinicians and staff, culturally competent education and training, and culturally competent health education" (ACP, 2004, p. 226).

Defining cultural competence is not sufficient for the development of cultural competence health care policies, academic curricula, and the practice of culturally competent care. In order to have an operational understanding of the term, one must understand the key principles on which cultural competence policies are based. In theory, cultural competence policies take patient-centeredness to a higher level by incorporating knowledge and practices which assist practitioners to provide patient care to patients whose health care practices and beliefs may differ from those associated with the Western medical model. Policies related to the provision of culturally competent care are best developed when they take into consideration key cultural competence principles. These principles include:

1. The use of an explanatory model where clinicians ask that patients explain their understanding of their illness from their own perspective
2. The identification and bridging of clinician and patient communication styles
3. The assessment of patients' decision-making preferences and the role of family in the health care decision-making and healing process

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4. The identification, understanding, and provider acceptance of patients' attitudes toward and use of both biomedicine and alternative medicine
5. The ability on the part of the provider to recognize cultural and possible health issues related to gender and sexuality
6. The use of negotiation strategies to negotiate treatment plans which consider the cultures and beliefs of both the physician and the patient
7. Methods for becoming aware of issues of mistrust and prejudice and the impact which race and ethnicity may have on the clinical decision making process (Betancourt and Green, 2010).

Understanding the key principles of cultural competence does not guarantee that one will truly value cultural competency or practice it. While the practical skills necessary to deliver culturally competent care have been clearly delineated in the literature, the "… governing attitudes clinicians ought to develop in conjunction with these skills have received far less attention" (Hyun, 2008, p. 155). For health care providers to truly take the value of cultural competence seriously, they must have three general commitments. As identified by Hyun (2008), these three commitments are to:

1. accept that patients' health beliefs and behaviors are significantly influenced by their social and cultural practices,
2. acknowledge the way in which health professionals respond to patients' varying social and cultural values at the various stages of the health care delivery system, and

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3. ensure the quality of health care delivery for culturally diverse patients by developing interventions apropos to fulfilling the first two commitments above.

The Timeliness of the Study

Driven in large degree by the population changes which are expected to increase the racial and ethnic diversity of the U.S. in the upcoming years, stakeholders in the health care and health care education fields are creating cultural competence policies and strategies to assist providers in the provision of a higher quality of care for the increasingly diverse population. A review of the literature shows that these policies and strategies originate with federal government policies and guidelines which, over time, impact the policies of other stakeholders in the health care arena. Below is a description of the most relevant federal initiatives creating the conditions for the timeliness of the study.

Federal Initiatives Related to Cultural Competence

Department of Health and Human Services and Cultural Competence

The effort to further the knowledge of cultural competence in health care is an appropriate endeavor at this time. As recently as April 24, 2013, the U.S. Department of Health and Human Services' Office of Minority Health (OMH) officially released an enhanced version of the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care. These standards provide health care organizations with culturally competent strategies to improve the health and health care of minority patient populations. Originally published in the Federal Register on December 22, 2000, these standards are recommended for adoption by stakeholder

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organizations and agencies. In short, the OMH prepared these standards because it believed that "…a lack of comprehensive standards has left organizations and providers with no clear guidance on how to provide CLAS in health care settings" (HHS, 2001). In an effort to take into consideration the increasingly diverse U.S. population, the ensuing increase in the diversity of the U.S. patient population, and the need for the delivery of culturally competent care, the HHS OMH developed the CLAS Standards stating:

> Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes (HHS, 2001).

Since the publishing of the newly enhanced National CLAS Standards in April of 2013, many states have proposed and/or passed cultural competency legislation pertaining to the training of health professionals (HHS Office of Minority Health [OMH], 2013). Currently, five states (Washington, California, Connecticut, New Jersey, and New Mexico) mandate that some form of cultural and linguistic competency be signed into law for all or a segment of the respective states' health care workforce" (HHS OMH, 2013). To view a project overview of the original CLAS standards, see Appendix C; to view the original National CLAS Standards of December 2000, see Appendix D; to see a fact sheet of the updated 2013 version of the National CLAS standards, view Appendix E, to see the enhanced national CLAS standards of April 2013, see Appendix F, and to

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see a depiction of legislative activity surrounding cultural competence in health care, see Appendix G.

The Affordable Care Act and Cultural Competence Provisions

Another current and major national initiative that supports the timeliness of the study is the implementation of the Patient Protection and Affordable Care Act of 2010. Many of the provisions of the Affordable Care Act (ACA) are intended to "...reduce health disparities and improve the health of racially and ethnically diverse populations" (Andrulis et al., 2010, p. 2). The ACA provisions which address cultural competence policies span across a minimum of six domains to include:

1. Data Collection and Reporting by Race, Ethnicity and Language
2. Workforce Diversity
3. Cultural Competence Education and Organizational Support
4. Health Disparities Research
5. Health Disparities Initiatives in Prevention
6. Addressing Disparities in Health Insurance Reforms (Andrulis et al., 2010).

Addressing the cultural competence issues related to these six domains becomes vital when viewed in the context of the demographic population changes expected to occur in the U.S. and necessitates a corresponding change in the delivery of care as diverse populations have diverse expectations of care, differences in the prevalence of types of illness and disease, and, consequently, different health care needs. To see more details regarding the sections of the ACA provisions which relate to each of the six domains above and how they address disparities through use of cultural competence, the national CLAS standards, and other disparity-reducing measures, see Appendix H.

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Increasingly, cultural competence policies will need to consider the practices which lend to the satisfaction of minority patient populations who will progressively become a larger portion of the patients receiving care. Understanding the requirements and preferences of racial and ethnic minorities will become an increasing concern as patient satisfaction scores begin to impact third-party reimbursements. In order to appeal to consumers, treat them effectively and satisfactorily, and maintain market share, health care administrators will need to assess and influence providers' capacities to provide care to a more diverse population. Although provisions of the Affordable Care Act support cultural competence at both the institutional and individual provider levels, "…questions remain regarding the extent to which these initiatives will be embraced" (Andrulis et al., 2010, p. 5). The study may very well provide insight as to how to best assure the incorporation of culturally competent initiatives that will be embraced at the provider and organizational levels.

Centers for Medicaid and Medicare Services (CMS) and Cultural Competence

CMS (2012) views cultural competency as "a vital component of professional competence" (p. 1) and states that culturally competent practice has many benefits to both health care practitioners and organizations. These stated benefits include:

- Improved patient care and satisfaction
- Decreased malpractice risk
- Enhanced operational efficiency
- Increased compliance with State and Federal regulations
- Reduction in health disparities (Centers for Medicaid and Medicare Services [CMS], 2012)

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To prepare providers to deliver quality care, CMS has Quality Improvement Organizations (QIOs) working with health care providers to increase their effectiveness and their awareness of how they care for diverse populations. The QIOs have adopted a guide called *A Physician's Practical Guide to Culturally Competent Care* as the "Program of Choice" for cultural competency education of health care providers. The guide is described by CMS as "…an innovative educational product designed to equip health care providers with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities" (CMS, 2012, p. 2). The guide is anchored in themes of the National CLAS Standards in Health and Health Care and assists with the Department of Health and Human Services' Office of Minority Health efforts to improve the health of racial and ethnic minorities through the development of policies and programs that assist in the elimination of disparities in health care (CMS, 2012). *A Physician's Practical Guide to Culturally Competent Care* is a self-directed web-based training course with Cultural Competency Curriculum Modules (CCCMs) commissioned by the OMH. The guide and its modules contain:

- self-assessments,
- case studies,
- video vignettes,
- learning points,
- pre- and posttests, and
- feedback opportunities

to prepare physicians and other health care professionals to provide higher quality care to the increasingly diverse U.S. patient population.

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Health Care and Medical Education Accrediting Bodies

The Joint Commission (TJC)

The Joint Commission "…views effective communication, cultural competence, and patient- and family-centered care as important components of safe, quality care" (TJC, 2010, p. 4). In an effort to assist hospitals with their efforts to provide all patients with high quality care, in 2010, TJC developed a monograph titled *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. This monograph is intended to inspire hospitals to incorporate concepts from the fields of cultural competence, communication, and patient- and family-centered care into their core activities. The roadmap addresses the continuum of care to include six stages:

- Admission
- Assessment
- Treatment
- End-of-Life Care
- Discharge and Transfer
- Organization Readiness

TJC (2010) suggests that hospitals use the road map to improve performance, train staff, help to inform policy, and evaluate compliance with relevant laws, regulations, and standards. It has identified five domains which are demonstrative of organizational preparedness to implement effective communication, cultural competence, and patient- and family-centered care; these domains and a description of each domain can be seen in Table 1. To view the Joint Commission's Checklist to Improve Effective

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Communication, Cultural Competence, and Patient- and Family-Centered Care across the Care Continuum, see Appendix I.

Table 1

The Joint Commission's Five Domains of Organization Readiness for Implementing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care

Domain	Description
Leadership	Leaders must clearly articulate a hospital's commitment to meet the unique needs of its patients to establish an organization culture that values effective communication, cultural competence, and patient- and family-centered care.
Data Collection and Use	The hospital must define what types of data to collect, how to collect data, and how to use data for service planning and resource allocation to advance effective communication, cultural competence, and patient- and family-centered care.
Workforce	The hospital and its staff, including the medical staff, must commit to meeting the unique needs of the patients they serve.
Provision of Care, Treatment, and Services	The hospital, in striving to meet the individual needs of each patient, must embed the concepts of effective communication, cultural competence, and patient- and family-centered care into the core activities of its care delivery system.
Patient, Family, and Community Engagement	The hospital must be prepared to respond to the changing needs and demographics of the patients, families, and the community served. The hospital can identify the need for new or modified services by being involved and engaged with patients, families, and the community.

Note. Adapted from *Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care: A Roadmap for Hospitals* by The Joint Commission, 2010, p. 35. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf.

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The Liaison Committee on Medical Education (LCME)

As the accrediting body of medical schools in both the U.S. and Canada, the LCME, a joint body of the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC), has determined specific areas of cultural competence which medical schools must incorporate to satisfy accreditation standards. In order to meet the requirements of accreditation and to maintain operating status, undergraduate medical schools must provide proof of compliance with the LCME's cultural competence standards. In its accreditation manual, *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree*, the LCME (2012) includes two cultural competency components. Regarding the structure and content of the educational program for the M.D. degree, the LCME (2012) standard ED-21 reads:

> The faculty and medical students of a medical education program must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.
>
> > *Instruction in the medical education program should stress the need for medical students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on patients' health. To demonstrate compliance with this standard, the medical education program should be able to document objectives relating to the development of skills in cultural competence, indicate the location in the*

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> *curriculum where medical students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.* (LCME, 2012, p. 10)

The LCME (2010) standard ED-22, which also addresses the educational structure and content of medical programs, reads:

> Medical students in a medical education program must learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the process of health care delivery.
>
> *The objectives for instruction in the medical education program should include medical student understanding of demographic influences on health care quality and effectiveness (e.g., racial and ethnic disparities in the diagnosis and treatment of diseases). The objectives should also address the need for self-awareness among medical students regarding any personal biases in their approach to health care delivery.* (LCME, 2012, p. 10)

Regarding the admission and selection of medical students, the LCME (2012) includes a diversity standard, standard MS-8, which reads:

> A medical education program must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission.
>
> *Because graduates of U.S. and Canadian medical schools may practice anywhere in their respective countries, it is expected that an institution that offers a medical education program will*

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recognize its collective responsibility for contributing to the diversity of the profession as a whole. To that end, a medical education program should work within its own institutions and/or collaborate with other institutions to make admission to medical education programs more accessible to potential applicants of diverse backgrounds. Institutions can accomplish that aim through a variety of approaches, including, but not limited to, the development and institutionalization of pipeline programs, collaborations with institutions and organizations that serve students from disadvantaged backgrounds, community service activities that heighten awareness of and interest in the profession, and academic enrichment programs for applicants who may not have taken traditional pre-medical coursework. (LCME, 2012, p. 17)

The Accreditation Council for Continued Medical Education (ACCME)

The ACCME (2012) has established 22 Accreditation Criteria which are organized in such a way as to allow providers to achieve one of three levels of accreditation status. The first, second, and third levels of ACCME accreditation are Provisional Accreditation, Full Accreditation/Reaccreditation, and Accreditation with Commendation, respectively. Of the ACCME 22 criteria, criterion number six can be most closely linked to cultural competence policy. Criterion six reads, "The provider develops activities/educational interventions in the context of desirable physician attributes [eg [sic.], Institute of Medicine (IOM) competencies, Accreditation Council for

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Graduate Medical Education (ACGME) Competencies]" (Accreditation Council for Continuing Medical Education, 2012, p. 1). In referencing IOM and ACGME competencies, the ACCME supports the cultural competence components of these competencies (see Appendix J for ACGME competencies and Appendix K for IOM competencies). Although it is not necessary for a provider to achieve criterion six to obtain Provisional Accreditation, it is, however, an essential attainment for providers wishing to achieve the second and third levels of Full Accreditation/Reaccreditation and Accreditation with Commendation.

The Accreditation Council for Graduate Medical Education (ACGME)

Graduate medical education is rarely managed by medical schools, but most always operates under the governance of hospitals and academic medical centers which have an affiliation with medical schools (McGaghie, 2007). The ACGME is responsible for the accreditation of many residency education programs throughout the U.S. The ACGME accreditation standards necessitate that all medical residency programs require its residents to have competence in the six areas of:

1. patient care,
2. medical knowledge,
3. practice-based learning and improvement,
4. interpersonal and communication skills,
5. professionalism, and
6. systems-based practice (ACGME, 2011).

Of these six ACGME (2011) competencies, two of them (competencies four and five) speak to cultural competence proficiencies. Competency Four – interpersonal and

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communication skills – stipulates that residents are to "…communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds" (pp. 8-9). Competency Five – professionalism – specifies that residents are to exhibit "…sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation" (p. 9). To fully appreciate the impact of residents obtaining these cultural competencies, they should be viewed in light of the ACGME's July 1, 2011 introduction to its updated Common Program Requirements which reads:

> Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients…. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. (ACGME, 2011, p. 1)

To learn more about the ACGME Competencies portion of the ACGME Common Program Requirements, refer again to Appendix J.

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Medical and Physician Organizations and Associations

Many medical and physician organizations and associations have policy positions related to the provision of culturally competent care. Some such organizations include the American Medical Association (AMA), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP). Those deemed to have the most robust policies with a strong presence in the literature have been included in the literature review.

The American Medical Association (AMA)

The AMA addresses issues of cultural competence from various perspectives. These perspectives include providing culturally competent dietary and nutritional guidelines to reduce obesity rates in minority populations, integrating cultural competence education and training in graduate education and continuing medical education, enhancing physicians' cultural competence, promoting health care practices that are culturally competent and effective, and educating physicians on "folk remedies" which may be in use among ethnic subgroups (AMA, 2012). Regarding the enhancement of the cultural competence of physicians, the AMA policy statement reads as follows:

The AMA will:

(1) continue to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula;

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(2) continue research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings;

(3) form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database;

(4) assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; and

(5) seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians), the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and

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> staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. (AMA, 2012)

For more information on AMA policies related to cultural competence, see Appendix L.

The American Academy of Family Physicians (AAFP)

The AAFP (2008) has produced a cultural competence position paper titled *Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities*. In its position paper the AAFP (2008) structures its cultural competence under three general headings. The first heading is an introduction titled *Importance of Improving Cultural Proficiency in the Delivery of Health Services*. In this introduction, the AAFP (2008) states its position that "cultural proficiency and linguistic competence are…fundamental aspects of quality in health care – especially for diverse patient populations – and are essential strategies for reducing disparities by improving access, utilization, and quality of care" (p. 1).

The second heading of the AAFP's position paper is titled *Organizing Principles*. This section begins by addressing physician education and states that:

> Health professionals should be aware of, and sensitive to, the cultural and ethnic diversity of patients they serve so they can develop and implement best practices such as providing interpreter services and culturally proficient care in their offices. Health professionals should be aware of the connection between good cross-cultural communication and ensuring patient safety. (American Academy of Family Physicians [AAFP], 2008, p. 2)

In addition to physician education, *Organizing Principles* also addresses the need for diversity within the health care workforce; the need to address issues of language access

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barriers (to include signage and written materials); the need for standardized data collection processes on patients' race, ethnicity, language, and other socio-cultural types of information; the need to address issues of health care access for underserved populations; the need to integrate and assess cultural competence measures into current quality assessment measures; the need to determine the best methods to pay for interpreter services and to compensate bilingual physicians and staff (AAFP, 2008).

The third and last heading of the AAFP (2008) position paper is titled *Policy Options*. This section is devoted to the AAFP's (2008) cultural competence policy position as related to Medicaid, Medicare, State Health Insurance Programs (SHIPs), managed care, and health plan organizations (to include both public and private Health Maintenance Organizations (HMO's). In brief, the AAFP believes that these entities have responsibility for ensuring the quality of culturally competent care and the provision and payment of medical interpretation services. To view the AAFP's (2008) *Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities (Position Paper)*, see Appendix M.

The American College of Physicians (ACP)

The ACP (2004) formally recognizes that "…minorities do not always receive the same quality of health care, do not have the same access to health care, are less represented in the health professions, and have poor overall health status than nonminorities" (p. 226). In support of efforts to address these issues, the ACP's staff, in collaboration with the ACP Health and Public Policy Committee, produced a position paper containing policy positions which they state "…will be the foundation for public policy advocacy by the ACP for eliminating racial and ethnic disparities in health care"

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(ACP, 2004, p. 226). To this end, the ACP has taken health care disparity reduction positions on six major fronts: “increasing access to quality health, patient care, provider issues, systems that deliver health care, societal concerns, and continued research” (ACP, 2004, p. 226). Using these six fronts as a basis for policy formation, in 2004, the ACP Board of Regents stated eight positions on eliminating racial and ethnic disparities in health care (see Table 2). For a more updated, 2010 version of the ACP position on cultural competence, see Appendix N.

In a 2004 study, it was reported that 98% of senior leaders in health care management were Caucasian (ACP, 2004). Based on the findings of this report, the ACP (2004) suggested that policymakers and administrators develop and implement policies which encourage organizations to make “…concerted efforts to recruit, prepare, and promote minorities to leadership positions in health care” (p. 230). The ACP (2004) believes these efforts to be appropriate since “…minority professionals may be more likely to consider the needs of minority populations when organizing health care delivery systems” (p. 230). To further its determination to increase the presence of professional minorities in health care leadership positions, the ACP (2004) promotes medical school admissions policies which take race and ethnicity into consideration. By increasing the number of minorities admitted to medical school, the ACP (2004) hopes to improve upon the diversity of the health care workforce. Over time, increased workforce diversity is expected to improve the quality of health care and health care outcomes for minority patients. As a corollary to this policy, the ACP (2004) also supports efforts to increase minority faculty at medical schools.

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The ACP (2004) acknowledges that “clear communication…is key to healthy patient outcomes, …better health status and functioning, greater patient satisfaction, and increased quality of care, which increases health care-seeking behavior” (p. 227). Although clear communication is paramount to the delivery of quality health care, a study performed by the United States Office of Management and Budget revealed that each year an estimated 66 million health care encounters occur through language barriers (ACP, 2004). Cultural competence policies aimed at providing interpretation services to limited English proficient patients are much needed if health care administrators are to improve this population’s access to medical services, provide a means by which to increase the quality of their health care, and improve upon their health outcomes. Unfortunately, one out of five Spanish-speaking patients does not seek medical care due to language barriers (ACP, 2004). If high-quality health care is to be provided to all residents of the United States (be they permanent or temporary residents), policymakers and health care administrators must ensure that timely interpretation services are consistently available to this and other limited English proficient populations.

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Table 2

American College of Physicians 2004 Cultural Competence Policy Positions

Position No.	Description
Position 1	All patients, regardless of race, ethnic origin, nationality, primary language, or religion, deserve high-quality health care.
Position 2	Providing all Americans with affordable health insurance is an essential part of eliminating racial and ethnic health disparities in health care.
Position 3	As our society increasingly becomes racially and ethnically diverse, health care providers need to acknowledge the culture of their patients.
Position 4	Physicians and other health care providers must be sensitive to cultural diversity among patients and recognize that inherent biases can lead to disparities in health care among racial and ethnic minorities. Cultural competence training should be incorporated in the training and professional development of all health care providers, at all levels.
Position 5	Action is needed throughout the entire continuum of the health care delivery system to address disparities in health care among racial and ethnic minorities.
Position 6	A diverse workforce of health professionals is an important part of eliminating disparities among racial and ethnic minorities.
Position 7	Many socioeconomic issues contribute to disparities in health care among racial and ethnic minorities. While all need to be addressed, ACP has specific recommendations concerning public education, targeting the sale of products that negatively impact the health of racial and ethnic minorities, and reducing deaths and injuries from firearms.
Position 8	Research is a vital part of identifying, monitoring, and addressing disparities in health care among racial and ethnic minorities. Research to identify sources of disparities, as well as effectiveness of initiatives targeted to eliminate disparities, will necessitate the collection of better data on race, ethnicity, and primary language, using reliable and standardized measurement tools.

Note. Adapted from "Racial and Ethnic Disparities in Health Care: A Position Paper of the American College of Physicians," by the American College of Physicians, August 2004, *Annals of Internal Medicine*, *141*(3), 226-232.

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Academic Medicine and Public Health

The Association of American Medical Colleges (AAMC)

Regarding the inclusion of cultural competence curricula in medical schools, the AAMC (2005) warns that "if issues such as culture, professionalism, and ethics are presented separately from other content areas, they risk becoming de-emphasized as fringe elements or of marginal importance" (p.2). The position of the AAMC (2005) is that cultural competence curricula is intended to "…enhance the patient-physician interaction and assure that students have the knowledge, skills, and attitudes that allow them to work effectively with patients and their families, as well as with other members of the medical community" (p. 2). The AAMC takes the position that the following conditions are institutional requirements for the effective establishment of cultural competence curricula:

- The curriculum must have the institutional support of the leadership, faculty, and students.
- Institutional and community resources must be committed to the curriculum.
- Community leaders must be sought out and involved in designing the curriculum and providing feedback.
- The institution and its faculty need to commit to providing integrated educational interventions appropriate to the level of the learner.
- A cultural competence curriculum must have a clearly defined evaluation process that includes accountability and evaluation (for example, evidence of a planning process to assure appropriate inclusion of material throughout the curriculum, details on curriculum process and content [including duration and

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types of educational experiences], specific student feedback, and consideration of outcomes assessment). (AAMC, 2005, p. 2)

In an effort to assist medical schools with the integration of cultural competence content into their existing curricula, the AAMC (2005) has developed an assessment tool to assess cultural competence training. This tool (the Tool for Assessing Cultural Competence Training (TACCT)), assists schools with meeting the LCME policies around caring for people of diverse cultures and recognizing and understanding cultural biases. The TACCT contains 5 five domains to be taken into consideration when the components of cultural competence curricula. Each of the five domains has specific knowledge, skills and attitudes that should be both taught and evaluated. The five domains are as follows:

1. Cultural Competence—Rationale, Context, and Definition
2. Key Aspects of Cultural Competence
3. Understanding the Impact of Stereotyping on Medical Decision-Making
4. Health Disparities and Factors Influencing Health
5. Cross-Cultural Clinical Skills

To see the content areas of each of the TACCT domains, see Appendix O. To see the knowledge, skills, and attitudes associated with each of the five TACCT domains, see Appendix P.

The AAMC and the Association of Schools of Public Health (ASPH) Joint Efforts

In 2009, select members of the Association of American Medical Colleges (AAMC) and the Association of Schools of Public Health (ASPH) met to vet issues of cultural competence in student education. The collaboration resulted in joint cultural

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competencies for medical and public health students. The resulting competencies were aligned with Krathwohl's (2002) revision of Bloom's taxonomy of educational outcomes; assigned to one of three domains of cultural competence categories: (a) knowledge, (b) skills; or (c) attitudes; and mapped to the Accreditation Council on Graduate Medical Education (ACGME) six core health care competencies:

1. Medical Knowledge
2. Patient Care
3. Interpersonal and Communication Skills
4. Professionalism
5. Practice-Based Learning and Improvement
6. Systems-Based Practice (Association of American Medical Colleges [AAMC] & Association of Schools of Public Health [ASPH], 2012)

These six ACGME core domains of competence are the predominant framework within the U.S. for competence-based outcomes. They are "…widely used by undergraduate medical education (UME) programs, required of graduate medical education (GME) residency programs, and adopted by the American Board of Medical Specialties for its maintenance of licensure program" (AAMC & ASPH, 2012)..

Regarding the purpose of these cultural competencies, the AAMC and the ASHP state, "The proposed competency sets reflect the nexus of medicine and public health cultural competence education and are intended to help embed cultural competence knowledge, skills, and attitudes in medical and public health education and practice" (AAMC & ASHP, 2012, p. 7). The AAMC and ASPH intended target audiences for the competencies are pre-graduate Doctor of Medicine (M.D.) students and Master of Public

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Health (M.P.H.) students. Students seeking doctorate degrees such as the Doctor of Public Health (Dr.P.H.), the Doctor of Philosophy (Ph.D.), and the Doctor of Science (Sc.D.) degrees are also encouraged to obtain these competencies as they are deemed to be foundational for advanced work at the doctoral level. See Appendix Q for the cultural competencies common to both medical and public health students. See Appendix R for a mapping of the AAMC and ASPH cultural competencies with the ACGME's core health care competencies.

Critique of Previous Relevant Studies

A review of the literature reveals a deficiency in specific studies examining physicians' perspectives of what cultural competence means to them. Nonetheless, several studies have been located which examined providers' perceptions as related to health disparities, delivering care to minority and immigrant patients, and *preparedness* to provide culturally competent care. In keeping with Rudestam and Newton's (2007) statement that "…it is taken for granted that the majority of the source material you have read will not make it directly into the literature review" (p. 65) and Shi's (2008) statement that the "…literature review has a narrow scope, typically restricted to those studies pertinent to the specific issue addressed by the primary research" (Shi, 2008, p. 107), this critique of studies will be limited to studies which involve physicians and their perspectives and/or attitudes in relation to an aspect of care deemed to be related to cultural competence. Eight studies were found to meet this criterion. The titles, authors, and publication dates are included in Table 3, and the studies are critiqued below.

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Table 3

Previous Studies Relevant to the Study

Title	Authors	Date Published
Medical Student, Physician, and Public Perceptions of Health Care Disparities	Wilson, Grumbach, Huebner, Agrawal, and Bindman	November-December 2004
Cultural Competence and Health Care Disparities: Key Perspectives and Trends	Betancourt, Green, Carrillo, and Park	March/April 2005
Resident Physicians' Preparedness to Provide Cross-Cultural Care	Weissman, Betancourt, Campbell, Park, Kim, Clarridge, Blumenthal, Lee, and Maina	September 2005
Personal Characteristics Associated with Resident Physicians' Self Perceptions of Preparedness to Deliver Cross-Cultural Care	Lopez, Vranceanu, Cohen, Betancourt, and Weissman	September 2008
Measuring Residents' Perceived Preparedness and Skillfulness to Deliver Cross-cultural Care	Park, Chun, Betancourt, Green, and Weissman	June 2009
Physician Cultural Competence and Patient Ratings of the Patient-Physician Relationship	Paez, Allen, Beach, Carson, and Cooper	February 2009
Development and Validation of EMP-3: An Instrument to Measure Physician's [sic.] Attitudes Toward Ethnic Minority Patients	De Maesschalck, Willems, De Maesseneer, and Deveugele	April 2010
Measuring Physicians' and Medical Students' Attitudes Toward Caring for Immigrant Patients	Hudelson, Perron, and Perneger	December 2010

The Wilson, Grumbach, Huebner, Agrawal, and Bindman (2004) Study

The objective of the *Medical Student, Physician, and Public Perceptions of Health Care Disparities* study was to both investigate the perceptions which first- and fourth-year medical students had toward health care disparities and to compare their

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perceptions with those of physicians and the public. Upon examination of the study, one finds that a major limitation of the study is that the three groups studied (medical students, physicians, and the public) were not given identical surveys and were surveyed in different years. These conditions made it difficult to accurately compare for and report differences among response groups (Wilson et al., 2004). To improve upon this study, study participants should have been given identical questionnaires within a closer proximity of time.

Regardless of any limitations, this study made major contributions to increasing knowledge about perceptions of health care disparities among the groups studied. One such contribution, for example, is one of the study's conclusions that the further along one was in his or her medical training, the less likely he or she was to perceive unfair treatment of patients. This conclusion suggests that those further into their medical careers were somehow less sensitized to or less likely to notice unfair treatment than those who were in the early stages of their careers. Thus, it was also determined that medical students in health care systems were more likely to perceive unfairness than physicians were (Wilson et al., 2004). Additional contributions of the study include: (a) its conclusion that although most medical students and the public believed that "people are treated unfairly based on the amount of money they have, their ability to speak English, and their race or ethnic background" (Wilson et al., 2004, p. 718), physicians believed otherwise; (b) its finding that minority students and minority physicians were more inclined to perceive greater levels of unfairness than non-minority students and physicians; and (c) its discovery that most of the medical students in the study desired

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greater exposure to issues of disparities and supported efforts to increase diversity within the medical workforce (Wilson et al., 2004).

Although this previous study is relevant to the current study in that it examines physicians' perspectives of health care disparities, it differs from the current study in that it does not examine physicians' perspectives of cultural competence – a possible solution to disparities in health care. At the time this study was conducted, in 2004, its authors claimed that no prior research had been done to investigate medical students' and physicians' attitudes about health care disparities. Likewise, at the time of the study, no research had been performed to ascertain whether or not students and physicians believed that these disparities were a reflection of a lack of fairness in the health care system. Since this study, consensus now exists that disparate care is a reality and that cultural competence may reduce disparate care. A study to ascertain physicians' perceptions of cultural competence is an important next step in the reduction of health care disparities. This is especially true since, as the authors state, medical students' perceptions and physicians' perceptions are important because they influence medical school cultural competence and health policy curricula changes (Wilson et al., 2004).

The Betancourt, Green, Carrillo, and Park (2005) Study

The objective of the *Cultural Competence and Health Care Disparities: Key Perspectives and Trends* study was to report the findings from a previous qualitative study where interviews were conducted with cultural competence experts from managed care, government (to include federal, state, and county departments of health), and academe (to include professional organizations, medical schools, and residency programs). The expert informants interviewed for this study were asked to (a) identify

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components of cultural competence which lent themselves to action, (b) describe areas in which leverage could be gained to implement action, and (c) identify associations to quality care and racial and ethnic disparity elimination in health care. Although this study contributes knowledge to the field of cultural competence, an obvious limitation of the study is the absence of perspectives of cultural competence from the viewpoint of physicians. Another limitation of this study is that it does not include the perspectives of those stakeholders for whom the practice of cultural competence is intended to assist, namely, racial and ethnic minority patients.

In spite of limitations, much learning was gained from this study. From the perspective of managed care, researchers learned that cultural competence was viewed as being driven by both quality and business necessities; that cultural competence was thought to increase the efficiency and effectiveness of care which, in turn, would control costs; and that it was believed that training in cultural competence should be standardized and evidence based in order to achieve “buy-in” from physicians (Betancourt et al., 2005). From the viewpoint of academe, researchers learned that cultural competence was seen as a skill set to be developed to improve the efficacy of provider-patient communication and quality care; that there is concern about the variability of quality in cultural competence training; and that there is a desire for more outcomes-based research to be conducted on cultural competence initiatives (Betancourt et al., 2005). From the viewpoint of government, researchers learned that cultural competence experts believed that there is a need to increase access to health care for vulnerable populations; that workforce diversity, interpreter services, and outcomes-based data collection were important components of cultural competence; that the need to leverage cost savings and

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quality improvement were thought of as benefits of cultural competence; and that Culturally and Linguistically Appropriate Services (CLAS) were deemed to be the blueprint to improve the U.S. health care system (Betancourt et al., 2005).

Although this study is like the current study in that it uses qualitative methods to capture the perspectives of stakeholders of cultural competence in health care, it is different from the current study in that it neglects to gain the perspective of physicians whose "buy-in" is essential to the success of culturally competence health care. Like the Wilson et al. (2004) study, the Betancourt et al. (2005) study further demonstrates a gap in the literature and a need for the current study. Physicians' perspectives and perceptions of culturally competent care must be obtained in order to further the knowledge in this field of study.

The Weissman, Betancourt, Campbell, Park, Kim, Clarridge, Blumenthal, Lee, and Maina (2005) Study

The stated objectives of the *Resident Physicians' Preparedness to Provide Cross-Cultural Care* study were to (a) examine the attitudes which medical residents had toward cross-cultural care, (b) explore the perceptions of their readiness to deliver quality care to a diverse patient population, and (c) assess the educational experiences and climate which residents encountered around cross-cultural training. When critiquing this study, one notes several limitations, some of which the authors note as well. Limitations include failing to mention any noted differences among study respondents and non-respondents, a lack of racial and ethnic diversity among respondents with an overrepresentation of white respondents, a limited number of specialties sampled, and a reliance on self-assessments of skill-level (Weissman et al., 2005).

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Even with its limitations, this study is important for the knowledge which it contributes to the study of perceptions of physicians who provide care to patients from cultures which differ from their own. The contributions which this study made to the field of cultural competence were its conclusions that many physicians believed that they were not prepared to deliver care to (a) patients with health beliefs contrary to those promoted by Western medicine, (b) newly arrived immigrants, and (c) patients whose treatment would be impacted by religious beliefs. This study also has significance in that the authors of this study claim that it was the first, to their knowledge, to "…obtain a national estimate of the readiness of new physicians to deliver high-quality care to diverse populations" (Weissman et al., 2005, p. 1066).

While this study evaluates practitioners' perceptions around preparedness to provide cross-cultural care, it differs from the current study in that it does not specifically address physicians' perceptions of what culturally competent care means to them. Although this study further elucidates perceptions around issues which may hinder the delivery of high-quality cross-cultural care, it does not investigate perceptions around strategies meant to eliminate issues related to the provision of cross-cultural care. Again, one can see the need for a study which investigates physicians' perspectives of culturally competent care.

The Lopez, Vranceanu, Cohen, Betancourt, and Weissman (2008) Study

The objective of the *Personal Characteristics Associated with Resident Physicians' Self Perceptions of Preparedness to Deliver Cross-Cultural Care* study was to determine whether or not resident physicians' social cultural traits influenced their self-perceived *preparedness* to deliver culturally competent care and/or their self-

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perceived *skill* to deliver culturally competent care. Upon reviewing this study, one obvious limitation was the study's reliance on self-perceived levels of preparedness and skill; these self-assessments of preparedness and skill were prone to biases inherent in self-reporting. In addition to this limitation, another shortcoming of the study was its inability to use these self-reported preparedness and skills to "…predict future abilities, actual provision of care, or the quality of care provided" (Lopez et al., 2008, p. 1957). A third limitation of the study is that it relies on the perceptions of those giving care and not those receiving care. This study could be improved upon by examining the preparedness and skill of physicians to deliver culturally competent care by obtaining this assessment from the perspectives of the patients for whom the physicians are providing care.

One of the most important findings of this study is its discovery that the most relevant factor associated with resident physicians' perceived improved cultural competence skills is the cross-cultural training received during residency. These findings are significant in that they support the need for and stress the importance of cultural competence policy and curricula in residency programs. The study also revealed that, when making comparisons among diverse racial and ethnic groups of resident physicians, differences were found to exist around perceived preparedness to deal with different cultural issues which present with diverse patient populations. This finding is significant to the field of cultural competence in that is supports cultural competence policies promoting increased work-force diversity as a means of improving care to diverse patient populations.

Although this study's findings are significant to improving the delivery of health care to diverse patient populations, it does not directly address physicians' perspectives

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of cultural competence. With cultural competence emerging as the disparity-reducing strategy of choice, researchers need to gain a greater understanding of this strategy from the physicians' points of views. As such, the current study could greatly contribute knowledge to the field.

The Park, Chun, Betancourt, Green, and Weissman (2009) Study

The objective of the *Measuring Residents' Perceived Preparedness and Skillfulness to Deliver Cross-cultural Care* study was, much as the study name suggests, to develop a measure to assess residents' perceived readiness and capabilities to deliver cross-cultural care. Although this study is similar to the Lopez et al. (2008) study, a main difference between the objectives of the two studies is that the Park (2009) study did not associate residents' social cultural traits with their perceptions. One of the limitations of this study is that its generalizability is limited due to the fact that the researchers sampled residents from a limited number of specialties (Park et al., 2009). Additional limitations are that the study had only one sample from which to test the psychometric properties of the scale used since the study was not designed to be a stand-alone assessment of the scales validity and reliability, and the study used residents' self-assessments, which may or may not be accurate (Park et al., 2009).

Despite this study's limitations, it resulted in a scale which was determined to be internally consistent and to exhibit construct validity. This study contributes significantly to the current status of knowledge around cultural competence in that its efforts to quantify the impact of cultural competence training was an initial step building the foundation for future work in this area. The study's authors state that the measure can be used to both assess residents' perceived cross-cultural skill and preparedness both pre-

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and post-medical training programs in cultural competence and to compare residents' self-assessments of their cultural competence capacities to objective assessments of simulated or actual clinical interactions with diverse patient populations (Park et al., 2009).

Although this study quantifies the results of cultural competence training efforts, it differs from the current study in that it does not ascertain physicians' perspectives of cultural competence and what it means to them. As such, this study does not preclude the need for the current study. Consequently, a qualitative study describing physicians' perspectives of cultural competence has the potential to add knowledge to the field of cultural competence in health care.

The Paez, Allen, Beach, Carson, and Cooper (2009) Study

The objective of the *Physician Cultural Competence and Patient Ratings of the Patient-Physician Relationship* study was to examine the association of patients' assessments of patient-physician relationships with the self-reported cultural competence of physicians by comparing cultural competence survey results of physicians to patient interview responses of their experiences with the same surveyed physicians. A major limitation of this study is that its authors were unable to find a standardized measure of cultural competency, and, as a result, developed their own measure which was not rigorously tested prior to its use (Paez et al., 2009). Also, as with the previously critiqued studies, this study relied on self-reported measures and its results were "…subject to social desirability bias" (Paez et al., 2009). Additionally, because patients in the study were surveyed as long as nine months after their physician visit, the authors admit that

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information obtained from patients may have been subject to recall bias (Paez et al., 2009).

In spite of its limitations, this study contributes to the current knowledge of cultural competence by reporting that patients of physicians who self-reported greater motivation to learn about other cultures and exhibited more culturally competent behaviors experienced higher levels of satisfaction, thought of their physicians as more facilitative, and reported both seeking and sharing greater amounts of information (Paez et al., 2009). This is an important finding since communication is an important element of the patient-physician relationship. Interestingly, the authors mention that patient perceptions of physicians' cultural competence was found to be related to patient satisfaction, while, ironically, physicians' perceptions of their own cultural competence was not (Paez et al., 2009). An additional contribution of this study is that it fills a gap seen in previous studies by including patients' perspectives of physicians' cultural competence in the delivery of care.

Although this study was published six years ago, its authors claim, and a review of the literature supports, that "this study is one of the first to examine the association of physician self-reported CC [cultural competence] with the quality of the patient-physician relationship and patient participation in care" (Paez et al., 2009, p, 497). From this study, it can be seen that both behavioral and attitudinal components of cultural competence are important to developing quality, participative patient-physician relationships. Although this study assesses physicians' self-perceived cultural competence and compares it to the patient experience, it differs from the current study in that it does not explore what cultural competence means to physicians in the practice and delivery of health care. Yet,

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from the findings of this study, one can see that exploring physicians' attitudes and perceptions as they relate to cultural competence is an important next step in the field.

The De Maesschalck, Willems, De Maesseneer, and Deveugele (2010) Study

The objective of the *Development and Validation of EMP-3: An Instrument to Measure Physician's [sic.] Attitudes Toward Ethnic Minority Patients* study was to evaluate physicians' attitudes and perceptions as they relate to cultural diversity or differences. The premise of this study was based on the author's assumption that "physicians' attitudes and perceptions toward cultural diversity in health care could be partly contributing to difficulties in communication between physicians and ethnic minority patients" (De Maesschalck et al., 2010, p. 262). There are two noted limitations to this study. As acknowledged by its authors, one limitation is the potential for the study results to be biased toward socially desirable responses because the researchers used a self-administered instrument. A second limitation is its sample of physicians which is both small in size and homogenous (112 family physicians) and limits the applications of the study (De Maesschalck et al., 2010)

A major contribution of this study is the development of a moderately valid and reliable three-factor instrument (the Ethnic Minority Patient (EMP-3) instrument) which evaluates physicians' perceptions and attitudes toward cultural diversity in the health care setting. The instrument assesses: "(1) physicians' task perception and ideas on cultural differences in health and health care, (2) physicians' attitudes toward physician-patient communication with minority patients, and (3) physicians' perception of minority patients' needs in communication" (De Maesschalck, 2010, p. 262). This study reports gender differences in physicians' attitudes toward ethnic minority patients and revealed

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that female physicians were noted to have more positive attitudes toward "…physician-patient communication with minority patients" (p. 265). This study also informed researchers that despite adaptation of cultural awareness standards in health care, many of these standards failed to be met. The authors report that "…physicians tend to behave less affectively with cultural minority patients: they show less empathic utterances, both verbally and nonverbally, and ask fewer psychosocial questions" (p. 262).

This study's contributions are important because, as its authors state, "Investigating physicians' perceptions of and attitudes toward cultural diversity in health care is an important first step toward improving culturally appropriate care" (De Maesschalck, 2010, p. 262). This notwithstanding, this study differs from the current study in that it measures physicians' attitudes toward racial and ethnic minority patients but does not assess physicians' attitudes and perceptions towards the provision of culturally competent care. At this time, it is the study of physicians' perspectives of cultural competence which may contribute an even greater understanding of the strategy which may potentially improve the quality of health and health care for racial and ethnic minorities.

The Hudelson, Perron, and Perneger (2010) Study

The objective of the *Measuring Physicians' and Medical Students' Attitudes Toward Caring for Immigrant Patients* study was, as the title states, to measure physicians' and medical students' attitudes as specifically related to caring for immigrant patients. Like previous studies included in this review, this study also used a self-administered questionnaire and is subject to the bias inherent in employing this type of a tool. Although this study found a positive association between cultural competence

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training and attitudes and opinions toward providing care for immigrant patients, its authors warn that these findings could be biased since it is unclear whether physicians and medical students with positive attitudes and opinions toward caring for immigrant patients are more likely to participate in cultural competence training or whether cultural competence training produces physicians and medical students with positive attitudes toward caring for immigrant patients (Hudelson et al., 2010). Another limitation of this study was its low response rate of 42% (N= 619).

This study contributes to the study of cultural competence in many ways. In addition to discovering a positive association between physicians' and medical students' attitudes and opinions toward providing care for immigrant patients and cultural competence training, the study is the first known study to demonstrate that female physicians and medical students consistently demonstrated more positive attitudes than men in the area of caring for immigrant patients (Hudelson et al., 2010). This is a finding somewhat similar to that in the De Maesschalck et al. (2010) study where female physicians possessed more positive attitudes toward caring for minority patients. The study also reported that, in general, younger respondents demonstrated more positive attitudes toward immigrant care than did older respondents (Hudelson et al., 2010). Surprisingly, the study also revealed that physicians who either reported work experience abroad and/or had larger numbers of immigrant patients placed a greater onus on the patient to adapt to the culture of the health care system than for the providers and system to adapt to the needs of the patient through the provision of culturally competent, patient-centered care (Hudelson et al., 2010). Additionally, the results of the study demonstrate to stakeholders that:

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> The knowledge and skills associated with clinical cultural competence are generally believed to be something that can be taught and learned. However, acquisition of knowledge and skills alone will not ensure their effective use in clinical practice; it seems likely that physicians also need to develop positive attitudes toward the care of immigrant patients. However, the specific attitudes necessary to ensure culturally competent clinical practice have not been well defined…. (Hudelson et al., 2010, p. 453)

To further the contribution of knowledge in this area, Hudelson, et al. (2010) determined that culturally competent attitudes include "…a high level of interest in caring for immigrant patients, an acceptance of the responsibility of doctors and hospitals to adapt to immigrant patients' needs, and the opinion that understanding the patient's psychosocial context is particularly important when caring for immigrant patients" (p. 452).

Although this study differs from the current study in that it looks at physicians' attitudes toward providing care to immigrant patients as opposed to physician's perceptions of culturally competent care, from this study, and others, one may see the importance of examining attitudes and perspectives and the implications and associations which they may have in relation to patient care. Just as attitudes and perspectives are an important aspect of caring for immigrant patients, they are an important aspect of the provision of culturally competent care as well. As such, one can clearly see the value in and need for a study which examines physicians' perspectives of cultural competence.

In summary, past studies have examined physicians' attitudes toward various components of diversity. Regardless of any limitations which these studies have had, in

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various ways, they have contributed to some aspect of the understanding of cultural competence. Although researchers have made advances both in understanding physicians' perspectives of diversity-related issues and in understanding components of cultural competence in health care, gaps in the literature still exist and research is needed in order to fill them.

The Appropriateness of the Study

Given the projected population changes, the documented and persistent presence of disparities, and the plethora of cultural competence initiatives in government, academe, organizations, and associations, it is clear that cultural competence is emerging as a foundational strategy for quality improvement in health care. Yet, with all its support from various stakeholder groups, there is much to learn about how to best implement and deliver culturally competent care, and facets of cultural competence continue to be worthy of study. Even though cultural competence policies and curricula are detailed and robust and cultural competence education and training is thought to be efficacious in the improvement of knowledge, skills, and attitudes of medical students, physicians, and other health care providers, these enhancements are not necessarily improving the health care practices of providers, increasing the quality of the health status or care of ethnic and minority patients, or reducing the disparities experienced by ethnic and racial minority populations.

Although past studies have made significant contributions to the field of cultural competence and some similarities exist between previously conducted studies and the current study, there are distinctions which warrant the pursuit of the latter. A qualitative study of physicians and their perspectives of culturally competent care is needed for its

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propensity to provide researchers with greater information about the impact of cultural competence and to discover the missing link between cultural competence policy, education, and training and practice and outcomes. While it is clear that physician "buy in" is an essential component for the advancement of the practice of culturally competent care, a better understanding of cultural competence from the perspective of physicians is needed to assist with securing physician "buy in" and to understand the barriers to providing care that is culturally responsive to and appropriate for diverse patient populations. As Hudelson et al. (2010) point out, "A better understanding of the role of physicians' attitudes in fostering cultural competence clinical practice, and of how such attitudes are acquired, is important for informing the development of effective training programs for physicians who work with diverse patient populations" (p. 454). From a review of the literature, it is clear that "…cultural competence among physicians is considered an important step toward… improving the quality of medical care for all patients" (Green et al., 2008, p. 1071) and that researchers need to gain a better understanding of cultural competence from physicians' perspectives. This study will advance the current understanding of cultural competence in health care by addressing gaps in the literature as they relate to physicians' perspective of culturally competent care.

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CHAPTER 3

Methodology

Introduction

The methodological procedures implemented in the study were chosen for their ability to contribute to the realization of the study's purpose (to explore and describe physicians' perspectives of what cultural competence means to them) and to explore the study's previously stated research questions:

1. What are physicians' perspectives around the importance of the practice of cultural competence in health care?
2. Do physicians perceive that cultural competence is practiced in health care?
3. What perspectives do physicians have regarding ways to increase physician engagement in culturally competent practices in health care?
4. What attitudes do physicians perceive as paramount to effectively practice cultural competence in health care?
5. What skills do physicians perceive as paramount to effectively practice cultural competence in health care?

Research Study Design

This study is an exploratory, descriptive, qualitative study that used phenomenology as its foundational philosophical approach and emphasized physicians' subjective interpretations and experiences with cultural competence. For this study, a

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qualitative interview technique was used. This technique was deemed appropriate for its applicability to the descriptive nature and purpose of the study. The selected study design was intended to capture and describe physicians' perspectives as related to the aforementioned study questions. The choice of a qualitative interview is supported by the literature and, as Yin (2011) states, "Doing qualitative interviews is likely to be the overwhelmingly dominant mode of interviewing in qualitative research" (p. 134). This qualitative design is appropriate for the study of cultural competence and is supported by the American Association of Medical Colleges (AAMC) which states that "…qualitative strategies are required to appropriately assess the impact of cross-cultural curricula" (AAMC 2005, p. 2). A presentation by J. G. Szarka (personal communication, April 29, 2013) from the Health Services Research and Development (HSR&D) Center of Excellence, informed webinar attendees that qualitative designs are used in studies for their ability to "…elicit rich descriptions..." and "…give participants more freedom to share…" their experiences and to share "…how they perceive their experiences." In further support of the appropriateness of a qualitative study design, a qualitative study exploring perspectives and trends related to cultural competence from the viewpoints of managed care, academia, and government was conducted in 2005 by Betancourt, Green, Carrillo, and Park. This qualitative study is relevant to the current study in that it helped to inform the researcher of the omission of physicians' perspectives toward cultural competence, examined perspectives of cultural competence from influential stakeholders in healthcare, and used a study design and sampling techniques which informed the current study.

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The Role of the Researcher

Although the role of the researcher conducting interviews is to manage the interaction between the researcher (the interviewer) and the participants (the interviewees) in order to explore the study topic, the role of the researcher conducting qualitative interviews differs from that of the researcher conducting structured interviews. For a researcher conducting a qualitative interview, "…the relationship between the researcher and the participant is not strictly scripted" and "there is no questionnaire containing the *complete list* of questions to be posed to a participant" (Yin, 2011, p. 134). Yet, the role of the qualitative interviewer does require that a mental framework of study questions be prepared. An additional requirement of the qualitative interviewer is that she or he individualizes her or his demeanor and relationship to each individualized participant (this differs from a structured interview where the researcher attempts to have a demeanor that remains uniform with all participants (Yin, 2011)). Given the nature of the qualitative interview, it is also extremely important that the researcher understand that her or his role as a listener is to listen "…to hear the meaning of what is being said" (Rubin & Rubin, 1995, p. 7). During the qualitative interviews for this study, the role of the researcher was as suggested by Yin (2011):

1. To speak in modest amounts
2. To be nondirective
3. To stay neutral
4. To maintain rapport
5. To use an interview protocol
6. To analyze and make process decisions while interviewing

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To meet the exigencies of this role, the researcher spoke in modest amounts by taking the predominant role as an active listener. She was nondirective in that she allowed the participants to direct the flow of the discussion, once interview topics had been introduced, and she avoided the temptation to ask leading questions and/or to make potentially leading comments. To maintain neutrality, the researcher refrained from expressing opinions about the content of the participants' responses, but clarified the meaning of participants' responses, when necessary. Rapport was established and maintained by the expression of verbal signs of attentiveness and interest in respondents' perspectives and the expression of gratitude for respondents' responses. These activities were not scripted or uniform, but were individualized according to the researcher's relationship with each individual participant. The interviewer used the interview protocol during the interview and made any process decisions, as warranted.

Sampling Procedures

Types of Sampling Used

Purposive sampling is employed in qualitative research (Cresswell, 2013), and purposive sampling was performed to identify respondents for this study. In purposive sampling, "…the inquirer selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study" (Cresswell, 2013, p. 156). Through this type of sampling, study participants are deliberately selected to yield the most relevant and abundant data given the topic of study (Yin, 2011).

Of the many types of purposive sampling strategies used in qualitative inquiry, this study used snowball sampling (also known as chain sampling) to identify physicians

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who met the specified criteria for study participants. Snowball sampling uses study participants and/or informants to identify subsequent participants which meet the study criteria. In this study, this sampling technique was also used to facilitate the identification of physicians willing to participate in the study, since physicians are generally thought to be difficult to recruit and access. Purposive and snowball sampling were used in the previously mentioned study by Betancourt, Carrillo, and Green (2005) in which participants from managed care, government, and academe were identified through these two types of sampling procedures and later interviewed about their perspectives of specific aspects of culturally competent care.

Potential Issues with Snowball Sampling

Although snowball sampling has the advantage of facilitating access to specific populations, Biernacki & Waldorf (1981) reveal that this sampling method has been associated with specific problems. Issues may include:

- finding initial respondents;
- starting referral chains;
- verifying the suitability of potential respondents;
- engaging respondents in the referral process;
- controlling chain types and the number of cases in any given chain;
- pacing the rate at which chains are referred; and
- monitoring the quality of chains and the quality of the data they produce.

Finding initial respondents and starting referral chains was not anticipated to be an issue for the study as inquiries at community events created an awareness of physicians who were interested in participating in the study and assisting with locating

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other potential respondents. The eligibility of respondents was discussed with each referral source, was included on the Project Description for Participants (see Figure 1), and was verified during the interview process through use of the research protocol. The engagement of respondents in the referral of potential future respondents was facilitated by the qualities emphasized by Biernacki and Waldorf (1981): the trust and rapport which the researcher built with respondents, the researcher's ability to impress upon respondents an understanding of the nature and importance of the study, respondents' perception of the quality of the study, and the researcher's astuteness as an interviewer. The development of referral chains was also facilitated by the importance which respondents had previously attached to the practice of cultural competence. Chain types manifested during the study and, due to their being relatively narrow in breadth (as was expected due to the predetermined participant criteria), the researcher did not find that they needed to be controlled. The pace at which referral chains were developed, the monitoring for the quality of the chains, and the quality of the data collected was determined by analyzing the data throughout the research process and using its contents to determine future pacing and sampling needs.

Sample Size

Unlike quantitative studies, for qualitative studies, "there is no formula for defining the desired number of instances..." to include in the study (Yin, 2011, p. 89). Likewise, where quantitative studies typically use large study samples, "qualitative researchers usually work with small samples of people, nested in their context…" (Miles, Huberman, & Saldaña, 2014, p. 31). For this study, the number of individuals contacted for participation in the study evolved over the course of the study and was based on

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“saturation” of ideas. This “saturation” occurred when respondent themes began to repeat themselves and new ideas were no longer generated and collected from respondents. This evolution of the number of individuals contacted for the study was consistent with Miles, Huberman, and Saldaña’s observation that “samples in qualitative studies are usually not wholly specified but can evolve…” (2014, p. 31). This notwithstanding, when researching a particular phenomenon, Polkinghorne (1989) suggests interviewing between five to 25 individuals who have experienced the phenomenon under study. For this study, it was expected that a range of eight to 15 participants would need to be interviewed to generate the amount of data appropriate for the study. The maximum number of participants to be recruited was 25.

Criteria and Rationale Used for Inclusion in the Sample

To guard against undermining the integrity of the study, criteria for inclusion into the sample was considered. Three criteria were considered necessary to ensure that the information obtained from study participants was commensurate with the purpose of the study. Those criteria, and the rationale for choosing them, were (a) that the participant currently practice as a physician – this was fundamental to the nature of the study, (b) that the participant practice as a primary care physician – this type of physician was expected to have greater exposure to diverse patient populations and to have sufficient experience with culturally divergent encounters, and (c) that the participant be under the age of 60 – this criterion was expected to increase the likelihood that the participant had some working knowledge of cultural competence in health care.

Step-by-Step Account of Sampling Procedures

Sampling was conducted as indicated below:

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1. The researcher spoke to physicians in her surrounding community to recruit the initial physician who was apprised of the details of the study, identified the initial participants who met the study criteria, verified with participants their willingness to participate in the study, and forwarded their contact information to the investigator.
2. The initial five participants were contacted via text message by the principal investigator who also verified with each participant that she/he was willing to participate in the study and made arrangements to interview each of these participants telephonically.
3. Participants were contacted by telephone at the arranged date and time and it was verified that they met the study criteria. Participants were interviewed, and at the close of each interview with the initial five physicians, the researcher reeducated each physician about the criteria for inclusion in the study, and participants were asked if they would be willing to assist with recruiting two additional physicians that both met each of the criterion for participation in the study and would be likely to be willing to participate in the study (if needed). The interviewer informed each participant that she would follow-up (via text) with the current participant if she were to request that the current participant make initial contact with other potential participants.
4. During the sampling process, the researcher found it necessary to reconnect with three physicians to obtain the additional participants necessary to reach a point of saturation in the data collection process. After collecting and analyzing data from 12 study participants, the researcher found that she had

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reached a point of saturation and that there was not a need for additional sampling.

Data Collection

Participants

Study participants consisted of practicing primary care physicians. The number of participants was determined during the data collection process and was deemed sufficient once a point of saturation of information was reached during the data collection process. Although at the beginning of the study this number was unknown, it was decided that a minimum of five participants and a maximum of 25 participants would be interviewed (Polkinghorne, 1989).

Study Site Selection

Interviews were conducted telephonically. The researcher placed the phone calls from her private office. The calls were placed to the phone number provided to the principal investigator by the referring participant.

Techniques

Once referred, respondents were texted to establish the interview date and time. At the time of the interview, participants were called, read brief introductory information about the study, and asked to verbally acknowledge their consent to participate in the study. Their verbal consent was then documented on the interview protocol. The researcher verified that participants were eligible for the study, and participants were given a verbal description of the project and interview process including the expected length of time of the interview (approximately 15-30 minutes), the use of note taking, plans for the interview results, the desire for frankness and openness on the part of the

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participant, and the assurance or anonymity of participant responses. During the interview process, participants were also provided with a definition of cultural competence. Additionally, participants were encouraged to ask any questions or express any concerns that they may have had regarding the interview (see Figure 1 to view the Project Description for Participants).

Research Protocols/Guides

In contrast to quantitative studies, qualitative studies typically rely more on *protocols* than on *instruments* (Yin, 2011). Although, on the one hand, even the presence of a research protocol has the potential to undermine the researcher's ability to accurately capture the perspectives of participants without influencing the data collected; on the other hand, since the researcher already identified key research questions, it was believed that a protocol would assist with guiding the study and the collection of data in a productive manner (Yin, 2011). Consequently, it was determined that a protocol would be used as an integral part of the study. As suggested by Creswell (2013), the interview guide/protocol contained five to six interview questions, and it consisted of the previously demarcated research questions which were evoked from the review of the literature (see Figure 2 and Figure 3 to view pages 1 and 2 of the Interview Protocol). The use of an interview protocol proved to be especially helpful given the time constraints associated with interviewing physicians.

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PROJECT DESCRIPTION FOR PARTICIPANTS OF DOCTORAL PROJECT: Physicians' Perspectives of Cultural Competence in Health Care

Purpose: To explore and describe physicians' perspectives of cultural competence in health care.

Definition of Cultural Competence: Cultural competence is defined as "…the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds." Cultural competence is considered to be a disparity-reduction strategy.

Eligibility: To be eligible for this study, physicians must (a) currently practice as a physician, (b) practice as a primary care physician, and (c) be under the age of 60.

Length of Interview Time: Approximately 15 - 30 minutes

Data Collection: The interviewer will be conducted telephonically and hand-written notes will be taken.

Plans for Interview Results: To inform academia, policymakers, and health care administrators.

Frankness and Openness: Please be frank, candid, and open with the interviewer without regard for any thoughts or opinions which you may assume the interviewer to have. This will be most conducive to the success of the study.

Anonymity: Study responses will be documented and presented anonymously; participants will not be identified by name in the study responses or results.

Questions or Concerns About the Project: Do you have any questions or concerns about the interview or any aspects of the project?

Figure 1. Project Description given to participant.

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INTERVIEW PROTOCOL FOR DOCTORAL PROJECT:
Physicians' Perspectives of Cultural Competence in Health Care

VERBAL CONSENT OBTAINED **YES** ☐ **NO** ☐

ELIGIBILITY REQUIREMENTS
(a) currently practicing ☐ **(b)** primary care physician ☐ **(c)** under 60 years of age ☐

VERBAL DESCRIPTION OF PROJECT GIVEN ☐

INTERVIEW DETAILS
Date of Interview:

Time of Interview:

PARTICIPANT IDENTIFICATION
Participant Code:

PARTICIPANT DEMOGRAPHICS
Cultural Background:

Native Language:

Gender:

Age/Under 60:

PHYSICIAN EXPERIENCE
Type of Medical Practice:

Years of Practicing Medicine:

Figure 2. *Page 1 of 2 of the Interview Protocol for Doctoral Project: Physicians' Perspectives of Cultural Competence in Health Care*

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INTERVIEW PROTOCOL FOR DOCTORAL PROJECT:
Physicians' Perspectives of Cultural Competence in Health Care continued

INTERVIEW GUIDE

1. Given the provided definition of cultural competence, how important is the practice of cultural competence in health care to you? To other physicians?

2. Do physicians practice cultural competence?

3. What can be done to further engage physicians in cultural competence?

4. What attitudes should physicians possess to effectively practice cultural competence? In your experience, do most have these attitudes?

5. What skills should physicians possess to effectively practice cultural competence? In your experience, do most have these skills?

ASK FOR ANY ADDITIONAL INFORMATION THAT THE PARTICIPANT MAY WANT TO SHARE.

ASK PHYSICIANS TO IDENTIFY TWO ADDITIONAL PHYSICIANS WHO MAY BE WILLING TO PARTICIPANT IN THE STUDY (IF NEEDED) AND IF SHE/HE WOULD BE WILLING TO MAKE THE INITIAL CONTACT WITH THESE PHYSICIANS (IF NECESSARY AND UPON AND EMAIL REQUEST FROM THE RESEARCHER).

THANK THE PARTICIPANT. ASSURE THE PARTICIPANT OF CONFIDENTIALITY.

Figure 3. Page 2 of 2 of the Interview Protocol for Doctoral Project: Physicians' Perspectives of Cultural Competence in Health Care

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Note-taking and word processing

Data was collected from participants through the use of an interview protocol. The use of the protocol guided the interview process. The information provided by the participants was recorded on the interview protocol/guide and was word processed after each interview.

Collection Procedures in Order of Occurrence

Data collection procedures occurred in the following order:

1. The interviewer called the participants on the telephone, read the participant brief introductory information and obtained verbal consent.
2. The interviewer then verified eligibility with the participant.
3. The interviewer verbally presented the information on the Project Description for Participants and allowed the participant time to express any concerns or ask any questions that she/he may have had.
4. The interviewer addressed any concerns expressed and answered any questions asked by the participant.
5. The interviewer began to follow the interview protocol by writing the interview date and time; assigning the participant a code (for purposes of anonymity during the data collecting and reporting of the findings); and obtaining the participant's demographical information (including demographic information related to the respondent's type of medical practice and years of practice as a physician).
6. The interviewer proceeded to interview the participant using the guide on the interview protocol and wrote her or his responses on the interview protocol.

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7. The interviewer asked for clarification of responses, when necessary.
8. The interviewer performed member-checking by asking the respondents for verification of the accuracy of the researcher's interpretation of responses to enhance the trustworthiness of the data collected.
9. The interviewer asked the participant for any additional information that she/he would like to share.
10. The interviewer asked the participant to be prepared to identify two additional physicians to be interviewed (if needed) and if the respondent would be willing to make the initial contact with these potential participants (upon request from the researcher).
11. The interviewer reassured the participant of the confidentiality of her or his responses.
12. The interviewer restated how the information gathered would be used.
13. The interviewer thanked the participant for her or his time, for participating in the study, and for sharing her or his insights and perspectives.
14. The interviewer word processed the information gathered from the interview.

Data Analysis

Method

Initial Coding of Topics

Once gathered, each participant's interview data was typed into a Word document and loaded into a Computer Assisted Qualitative Data Analysis Software (CAQDAS) program. The Ethnograph 6.0.1.0 qualitative data analysis software was used for this purpose. Once each participants' responses were loaded into the Ethnograph 6.0.1.0

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software program, the data was analyzed for topics and each topic was assigned a code which was entered into the Ethnograph 6.0.1.0 next to the comment(s) from which the codes were derived. Coding strategies were "…compatibly 'mixed and matched' as needed" (Miles, Huberman, & Saldaña, 2014, p. 74) and included a mixture of *descriptive coding* – used to assign labels to topics which emerge during the qualitative data collection process; *in vivo coding* – used to capture words as expressed by participants and thought to be "…appropriate for virtually all qualitative studies but particularly for beginning qualitative researchers learning how to code data…" (Miles, Huberman, & Saldaña, 2014, p. 74); and *values coding* – used to differentiate data reflecting values, attitudes, and beliefs (Miles, Huberman, & Saldaña, 2014, p. 74). The researcher proceeded with this coding process for the data derived from each additional interview and protocol.

Themes of Aggregated Codes

After the data from each protocol were coded in the Ethnograph 6.0.1.0, codes from all protocols were reviewed as a whole and grouped according to similarity of ideas or themes that appeared in the aggregated response content. Once grouped into themes, theme names were assigned to each set of aggregated codes. Theme names were then entered into the Ethnograph 6.0.1.0 and associated with their respective set of coded data. The Ethnograph 6.0.1.0 was then used to produce documents which contained themes with their associated text and participant codes. These documents were then examined for further analysis of the data and assisted with the development of the report of findings.

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Report of Findings

Participant responses and perspectives were presented in text format. Any topics which were not conducive to being relayed in text were displayed as a matrix or figure. Findings were reported in a manuscript for a journal submission using the appropriate topics and breadth of information as requested of the author by the journal's manuscript submission criteria.

Trustworthiness

Member-checking

Throughout the interview process, the researcher asked respondents for feedback regarding any unclear responses or responses that she found difficult to interpret. Upon ending the interview, the researcher verified the trustworthiness of the data collected by summarizing the participants' responses and having the participant verify the researcher's interpretation of her or his responses. This member-checking was employed to establish the trustworthiness of the researcher's interpretations of the data collected. Member-checking has few criticisms. These include assuming that there is a "fixed" truth that can be confirmed by a respondent, confusing rather than confirming interpretations, and obscuring whose interpretation (the researcher's or the participant's) should carry the greatest weight, given that they differ (Robert Wood Johnson Foundation, 2008). Notwithstanding these criticisms, the benefits of member-checking include allowing participants to correct errors, allowing participants to provide additional information, and providing the researcher an opportunity to summarize initial findings (Robert Wood Johnson Foundation, 2008).

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Reflexive Bracketing

In order to bracket (or minimize) potential researcher biases and lessen their possible influence upon the data collection, analysis, and reporting processes, a reflexivity team (consisting of four health care diversity professional colleagues) met with the researcher prior to the data collection process and explored biases which the researcher may have had regarding the study. To prepare the reflexivity team members, the researcher provided each member of the team with the methods section of the study and an article titled "Ten Tips for Reflexive Bracketing" by Kathryn J. Ahern (1999). Team members read and studied this information to familiarize themselves with both the study and with reflexivity and bracketing (although some team members had previous knowledge of the reflexive bracketing process). After reading and studying the article, team members took the first five of 10 personal reflection exercises discussed in the article and posed questions to the researcher. The researcher considered these questions during the reflexivity session.

During this session, team members also pilot-tested the research questions and suggested ways for the researcher to perform additional reflexivity and bracketing both during and after the data collection process as well as after study conclusions had been drawn. Ahern's (1999) reflexivity and bracketing exercises were used further by the researcher to examine biases throughout these phases of the study. Exercises six through 10 (in conjunction with further consultation with diversity colleagues) were used to explore the researcher's personal feelings around the data collected, examine issues of saturation, and to assess the integrity of the conclusions drawn. These reflexivity and bracketing exercises assisted to further guard against biases being introduced into the

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study and allowed for a more accurate representation of the study participants' experiences.

Limitations

Social desirability bias may be a limitation of the study as participants may have felt inclined to provide interview responses which they deemed to be socially desirable. This possible inclination may have been exacerbated by the study's topic which addresses taboo subjects such as race, ethnicity, and culture. Another limitation of the study is the potential for the interviewer to inadvertently bias the data by influencing participants' responses as a result of the dynamics of the researcher/participant relationship or by misrepresenting the meaning of participants' responses as a result of the data analysis process. It should be noted that due to the nonprobability sampling techniques used, study results cannot be said to represent the general population.

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CHAPTER 4

Manuscript for Journal Submission

This chapter is written in the form of a submission-ready manuscript for submission to The Journal of the American Medical Association (JAMA). JAMA delineates several categories under which manuscripts may be submitted. Although JAMA provides authors with instructions in its Manuscript Preparation and Submission Requirements, each article category has its particular caveats and requirements. For this study, JAMA's Research Letter category is deemed most apropos in that it most closely meets both the JAMA category and the Medical University of South Carolina (MUSC) doctoral program requirements.

In order to meet JAMA's Research Letter requirements, the manuscript must be accompanied by a cover letter and include a title page, acknowledgement section, and references (all of which are included in this chapter). The manuscript must report original research, its length may not exceed 600 words of text, it may not contain more than 6 references, and it is limited to 2 tables or figures. Additionally, JAMA suggests that Research Letters be divided into 4 sections: Introduction, Methods, Results, and Discussion. These 4 sections are included here as well. Although JAMA articles typically contain an abstract, manuscripts submitted under the Research Letter category do not.

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In order to meet JAMA's requirements for manuscript submission, this chapter uses the manuscript style of the American Medical Association (AMA) Manual of Style (the former chapters use the American Psychological Association (APA) manuscript formatting style required for the MUSC doctoral project). Authorship and contributor credit for this manuscript was decided using the International Committee of Medical Journal Editors (ICMJE) authorship criteria. The manuscript's contents were compared to JAMA's Manuscript Checklist, and it is believed that the manuscript contains a comprehensive integration of JAMA manuscript requirements.

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Cover Letter

Spartanburg Regional Healthcare System
Department of Diversity and Language Services
101 East Wood Street
Spartanburg, SC 29303

Monday, August 3, 2015

Howard C. Bauchner, MD
Editor in Chief
The Journal of the American Medical Association (JAMA)
330 North Wabash Avenue
Chicago, IL 60611-5885

Dear Dr. Bauchner:

Please find enclosed a manuscript titled: "Physicians' Perceptions of Cultural Competence in Healthcare." I am submitting this manuscript for your consideration for publication in your journal. This Research Letter describes a phenomenological study in which physicians share their perspectives of cultural competence. It provides insights which will be helpful to medical education, healthcare policymakers, and healthcare administrators, and there are no previously published or submitted related papers from this study. As such, the contents of this paper should interest a readership interested in enhancing the patient-physician relationship, reducing healthcare disparities, enhancing medical education, and improving the delivery of quality care.

Thank you for your time and consideration. I am including my contact information for use at your discretion. My mailing address is Spartanburg Regional Healthcare System, 101 East Wood Street, Spartanburg, SC 29303. I am available by phone at 864-560-4088. I can be contacted via email at aaulmer@srhs.com. I can also be reached by fax at 864-560-7425. I hope to hear from you in the near future.

Sincerely,

Andrea L. Abercrombie, DHA
Department Head
Department of Diversity and Language Services
Spartanburg Regional Healthcare System

Attachment: manuscript

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Title Page

Category: Research Letter.

Title: Physicians' Perceptions of Cultural Competence in Healthcare.

Author: Andrea L. Abercrombie, DHA**.**

Author Affiliation: Spartanburg Regional Healthcare System, Department of Diversity and Language Services, Spartanburg, SC.

Submission Date: Monday, August 3, 2015.

Text word count: 600 words.

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Introduction

It is well documented in the United States that racial and ethnic minorities persistently experience disparities in both health and health care.[1] Health care system disparities have been ascribed to communication obstacles, cultural barriers, and provider influences such as racial and ethnic biases, stereotyping, and prejudices.[2] Cultural competence is a strategy deemed to have the potential to reduce health and health care disparities. Cultural competence is defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations.”[3(68)] Despite the adoption of cultural competence standards in medical schools and health care systems, many of these standards are not met when physicians deliver care to racially and ethnically diverse populations.[4] Examining physicians’ perspectives of cultural competence is important for its ability to inform academia and policymakers since physicians’ attitudes influence medical school cultural competence and health policy curricula changes.[5]

Methods

This qualitative study employed phenomenology as its foundational philosophical approach to explore and describe physicians’ perspectives and experiences with cultural competence. A semi-structured qualitative interview technique was used to explore 5 research questions related to physicians and the practice of culturally competent care **(Table)**. Study participants consisted of 5 female and 7 male primary care physicians (defined as practicing in the areas of family/general medicine, internal medicine, pediatric medicine, and/or obstetric/gynecological medicine). Participants were identified through snowball sampling technique and were interviewed telephonically.

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The acquired data was coded and analyzed using the Ethnograph 6.0.1.0 Computer Assisted Qualitative Data Analysis Software (CAQDAS) program.

Results

All study participants experienced the practice of cultural competence as important to them, and one participant stated that the practice of cultural competence is necessary “in order to be effective.” This notwithstanding, many participants experienced time constraints and a fear of offending patients as reasons why cultural competence is not practiced more often. In one participant’s experience, physicians “do not know how to ask culturally competent questions and may not ask for fear of being offensive.” Although the literature review revealed that provider biases toward racial and ethnic minorities may contribute to disparate care, some study participants did not believe that these biases existed among most physicians.

To further engage physicians in the practice of cultural competence, participants offered many suggestions including engaging physicians in dialogues where diverse patients described their personal experiences, perceptions of delivery of healthcare, and interactions with physicians; exposing physicians to case studies where cultural incompetence led to patient harm; including cultural competence education with the history-taking curriculum in medical school and residency training; allowing more time for the practice of cultural competence during patient visits; and teaching physicians how to ask culturally competent questions without offending patients.

Discussion

The efficacy of cultural competence is dependent upon physician support and buy-in.[6] Nevertheless, physician perspectives of cultural competence have received little

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consideration. Although diversity exists among physicians' attitudes, skills, knowledge, and practice of culturally competent care, physicians are concerned that barriers such as time constraints and a lack of knowledge around how to ask culturally competent questions make it difficult for them to effectively practice cultural competence in the healthcare setting. Academia, policymakers, and healthcare administrators will have to determine ways to facilitate the exploration and awareness of physicians' attitudes, skills, and potential unconscious biases in order to effect change and increase the practice of cultural competence standards during the delivery of care. These determinations will be an important step toward ensuring the success of cultural competence policies, training, education, and practices and potentially reducing health and health care disparities – the overarching goal of cultural competence in health care.

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Table

Table. Research Questions on Interview Protocol/Guide

Question Number	Research Question
1	Given the provided definition of cultural competence, how important is the practice of cultural competence in health care to you? How important do you think other physicians believe it to be?
2	Do physicians practice cultural competence?
3	What can be done to further engage physicians in the practice of cultural competence?
4	What attitudes should physicians possess to effectively practice cultural competence in health care? Do most have these attitudes?
5	What skills should physicians possess to effectively practice cultural competence in health care? Do most have these skills?

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Acknowledgement

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Contributions: Dr. Abercrombie had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Contributions were given without compensation.

Study concept and design: Abercrombie.

Acquisition, analysis, or interpretation of data: Abercrombie.

Drafting of the manuscript: Abercrombie.

Review of the manuscript: Abercrombie and all contributors.

Manuscript revision: Abercrombie.

Qualitative analysis: Abercrombie.

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Funding: Abercrombie.

Administrative, technical, or material support: Abercrombie.

Study supervision: Zoller.

Previous presentation of information: The author and contributors have not previously published or submitted any related papers from this same study.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Funding/Support: Dr. Abercrombie did not receive funding/support for the study.

Role of the Funder/Sponsor: No funder/sponsor reported.

Disclaimer: The views expressed in this article are those of the author and do not necessarily reflect the opinions of the author's institution.

Institutional Review Board Approval: The Medical University of South Carolina (MUSC) Office of Research Integrity (ORI) and the MUSC Institutional Review Board (IRB) for Human Research approved the research proposal for this study (Pro00037694) on December 03, 2014 as an Exempt study. Due to the nature of the data collection and the project being exempt from further IRB oversight, consent of participants was obtained telephonically and consent documents are not stamped by the IRB with an expiration date. The IRB Administrator on record is Katherine Bright.

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http://www.acponline.org/advocacy/where_we_stand/access/racial_disparities.pdf

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Appendix A

HHS Secretary's Foreword and Charge to the Task Force on Black and Minority Health

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

In January 1984--ten months after becoming Secretary of Health and Human Services--I sent Health, United States, 1983 to the Congress. It was the annual report card on the health status of the American people.

That report--like its predecessors--documented significant progress: Americans were living longer, infant mortality had continued to decline--the overall American health picture showed almost uniform improvement.

But, and that "but" signaled a sad and significant fact; there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole.

That disparity has existed ever since accurate federal record keeping began--more than a generation ago. And although our health charts do itemize steady gains in the health status of minority Americans, the stubborn disparity remained--an affront both to our ideals and to the ongoing genius of American medicine.

I felt--passionately--that it was time to decipher the message inherent in that disparity. In order to unravel the complex picture provided by our data and experience, I established a Secretarial Task Force whose broad assignment was the comprehensive investigation of the health problems of Blacks, Native Americans, Hispanics and Asian/Pacific Islanders.

The Task Force under the insightful direction of the distinguished Thomas E. Malone, Ph.D., Deputy Director of the National Institutes of Health and with the invaluable contribution of experts from throughout the department, has met its challenge. Brilliantly. First: by a review of departmental programs to determine how the health problems of minorities have been addressed; followed by a careful analysis of the range of health care resources and information available; and then--by a critique of the health status of Blacks, Native Americans, Hispanics and Asian/Pacific Islanders. The Task Force was further charged with finding ways for our department to exert leadership, influence and initiative to close the existing gap. The report is comprehensive. Its analysis is thoughtful. Its thrust is masterful. It sets the framework for meeting the challenge--for improving the health of minorities.

It can--it should--mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health.

Margaret M. Heckler

Margaret M. Heckler
Secretary

Source: *Report of the Secretary's Task Force on Black and Minority Health* (MH10D9924) by The United States Department of Health and Human Services, 1985. Washington, DC: Government Printing Office. Retrieved from http://health-equity.pitt.edu/3005/1/ANDERSON.pdf

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Appendix B

Minority Health and Health Disparities Research and Education Act of 2000

Title No.	Title Description	Section No.	Section Description
TITLE I	Improving Minority Health and Reducing Health Disparities through National Institutes of Health;	Sec. 101	Establishment of National Center on Minority Health and Health Disparities.
	Establishment of National Center	Sec. 102	Centers of excellence for research education and training.
		Sec. 103	Extramural loan repayment program for minority health disparities research.
		Sec. 104	General provisions regarding the Center.
		Sec. 105	Report regarding resources of National Institutes of Health dedicated to minority and other health disparities research.
TITLE II	Health Disparities Research by Agency for Healthcare Research and Quality	Sec. 201	Health disparities research by Agency for Healthcare Research and Quality.
TITLE III	Data Collection Relating to Race or Ethnicity	Sec. 301	Study and report by National Academy of Sciences.
TITLE IV	Health Professions Education	Sec. 401	Health professions education in health disparities.
		Sec. 402	National conference on health professions education and health disparities.
		Sec. 403	Advisory responsibilities in health professions education in health disparities and cultural competency.

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Appendix B *continued*

Minority Health and Health Disparities Research and Education Act of 2000

Title No.	Title Description	Section No.	Section Description
TITLE V	Public Awareness and Dissemination of Information on Health Disparities	Sec. 501	Public awareness and information dissemination.

Note. Adapted from *Minority Health and Health Disparities Research and Education Act of 2000*, Pub. L. No. 106 – 525, §1, 114 Stat. 2495 (2000). Retrieved from http://www.gpo.gov/fdsys/pkg/PLAW-106publ525/pdf/PLAW-106publ525.pdf.

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Appendix C

HHS OMH Project Overview for December 2000 CLAS standards

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes.

Unfortunately, a lack of comprehensive standards has left organizations and providers with no clear guidance on how to provide CLAS in health care settings. In 1997, the Office of Minority Health (OMH) undertook the development of national standards to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements concerning CLAS. The Office initiated a project to develop recommended national CLAS standards that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care.

The first stage of the project involved a review and analysis of existing cultural and linguistic competence standards and measures, the development of draft standards, and revisions based on a review by a national advisory committee. The second stage focused on obtaining and incorporating input from organizations, agencies, and individuals that have a vital stake in the establishment of CLAS standards. Publication of standards in the Federal Register on December 15, 1999, announced a 4-month public comment period, which provided three regional meetings and a Web site as well as traditional avenues (mail and fax) for submitting feedback on the CLAS standards. A project team (consisting of staff members of OMH, its contractor, and subcontractor) analyzed public comments from 413 individuals or organizations and proposed revised standards, with accompanying commentaries, to a National Project Advisory Committee (NPAC). Deliberations and additional review by NPAC members informed further refinements of the standards.

In their final version, the CLAS standards reflect input from a broad range of stakeholders, including hospitals, community-based clinics, managed care organizations, home health agencies, and other types of health care organizations; physicians, nurses, and other providers; professional associations; State and Federal agencies and other policymakers; purchasers of health care; accreditation and credentialing agencies; educators; and patient advocates, advocacy groups, and consumers.

The CLAS standards were published in final form in the Federal Register on December 22, 2000, as recommended national standards for adoption or adaptation by stakeholder organizations and agencies.

Source: Adapted from *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report* by The United States Department of Health and Human Services, 2001. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf.

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Appendix D

Original National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

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Appendix D *continued*

Original National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Standard 5
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10
Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

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Appendix D *continued*

Original National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Standard 12
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Source: The *U.S. Department of Health and Human Services Office of Minority Health website* (n.d.). Retrieved from http://minorityhealth.hhs.gov/.

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Appendix E

National CLAS Standards 2013 Fact Sheet

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

Purpose

The enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services.

The enhanced Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services.

History & Enhancement Initiative

The National CLAS Standards were first developed by the HHS Office of Minority Health in 2000. Following 10 years of successful implementation, the Office of Minority Health launched an initiative to update the Standards to reflect the tremendous growth in the field of cultural and linguistic competency since 2000 and the increasing diversity of the nation.

The Enhancement Initiative lasted from 2010 to 2013, and it had three major components: a public comment period, a systematic literature review, and ongoing consultations with an advisory committee comprised of leaders and experts from a variety of settings in the public and private sectors.

The Case for the National CLAS Standards

The enhanced National CLAS Standards were developed in response to health and health care disparities, changing demographics, and legal and accreditation requirements. With the Institute of Medicine's publication of *Unequal Treatment* in 2003, culturally and linguistically appropriate services gained recognition as an important way to help address the persistent disparities faced by our nation's diverse communities. There have also been rapid changes in demographic trends in the U.S. in the last decade. Additionally, national accreditation standards for professional licensure in the fields of medicine and nursing, and health care policies, such as the Affordable Care Act, have also helped to underscore the importance of cultural and linguistic competency as part of high quality health care and services.

The enhanced National CLAS Standards address these new developments and trends, and offer an even stronger framework to provide culturally and linguistically appropriate services. The enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities.

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Appendix E *continued*

National CLAS Standards Fact Sheet Developed 2013

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

Enhancements to the National CLAS Standards

The enhanced National CLAS Standards have a broader reach to address the importance of cultural and linguistic competency at every point of contact throughout the health care and health services continuum. Specifically, the Standards' conceptualization of culture, audience, health, and recipients were expanded

Expanded Standards	National CLAS Standards 2000	National CLAS Standards 2013
Culture	Defined in terms of racial, ethnic and linguistic groups	Defined in terms of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics
Audience	Health care organizations	Health and health care organizations
Health	Definition of health was implicit	Explicit definition of health to include physical, mental, social and spiritual well-being
Recipients	Patients and consumers	Individuals and groups

Given this conceptual foundation, the enhanced National CLAS Standards are structured as follows:

- Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Governance, Leadership, and Workforce (Standards 2-4)
- Communication and Language Assistance (Standards 5-8)
- Engagement, Continuous Improvement, and Accountability (Standards 9-15)

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Appendix E *continued*

National CLAS Standards Fact Sheet Developed 2013

Implementation Resource: *The Blueprint*
The Standards' implementation "on the ground" will vary from organization to organization. It is important for individuals and organizations to have a vision of what culturally and linguistically appropriate services will look like in practice and to identify available and required resources.

A Blueprint for Advancing and Sustaining CLAS Policy and Practice, or *The Blueprint*, is a new guidance document for the National CLAS Standards that discusses implementation strategies for each Standard. This resource and others relating to the National CLAS Standards are available at OMH's Think Cultural Health website: **www.ThinkCulturalHealth.hhs.gov**.

Next Steps
Successful implementation of the enhanced National CLAS Standards will depend on continued collaboration from the diverse stakeholders, as well as health care consumers. Please visit **www.ThinkCulturalHealth.hhs.gov** to learn more about promotion activities, collaboration opportunities, technical assistance, assessment and evaluation. Take action now by emailing your experiences related to CLAS to **AdvancingCLAS@ThinkCulturalHealth.hhs.gov**.

Source: The *U.S. Department of Health and Human Services Office of Minority Health Think Cultural Health website (2013)* by the U.S. Department of Health and Human Services. Retrieved from https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf.

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Appendix F

Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.

10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

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Appendix F *continued*

Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Engagement, Continuous Improvement, and Accountability continued:

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: The U.S. Department of Health and Human Services Office of Minority Health website (2013). Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=45#F.

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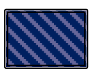
Appendix G

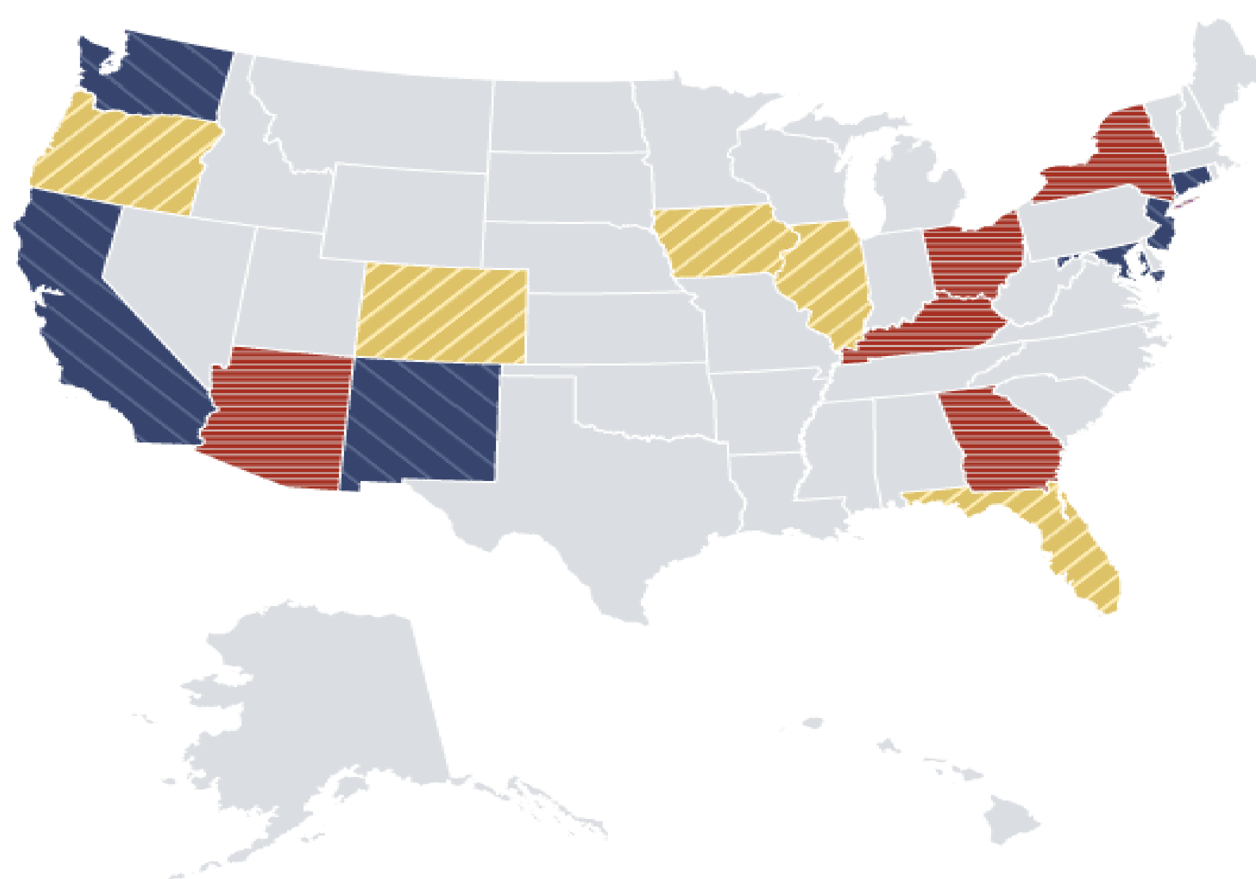
OMH Map of Cultural Competence Legislation Activities

State agencies have embraced the importance of cultural and linguistic competency in the decade since the initial publication of the CLAS Standards. A number of states have proposed or passed legislation pertaining to cultural competency training for one or more segments of their state's health professionals. At least six states have moved to mandate some form of cultural and linguistic competency for either all or a component of its health care workforce. Consult the map to see what states have proposed and/or passed legislation regarding cultural competency education.

 denotes legislation requiring (WA, CA, CT, NJ, NM) or strongly recommending (MD) cultural competence training that was signed into law.

denotes legislation that was referred to committee and/or is currently under consideration.

denotes legislation that died in committee or was vetoed.



Source: Adapted from HHS OMH website (2013). Retrieved from https://www.thinkculturalhealth.hhs.gov/Content/LegislatingCLAS.asp.

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Appendix H

Six Domains of Cultural Competence Provisions of the Affordable Care Act of 2010

Table H1

Domain 1: Data Collection & Reporting by Race, Ethnicity and Language

Affordable Care Act (ACA) Provision	ACA Section Number
Require that population surveys collect and report data on race, ethnicity and primary language	4302
Collect/report disparities data in Medicaid and Children's Health Insurance Program (CHIP)	4302
Monitor health disparities trends in federally-funded programs	4302

Note. Adapted from *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, by D. P. Andrulis, N. J. Siddiqui, J. P Purtle, and L. Duchon, July 2010. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

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Appendix H *continued*

Six Domains of Cultural Competence Provisions of the Affordable Care Act of 2010

Table H2

Domain 2: Workforce Diversity

Affordable Care Act (ACA) Provision	ACA Section Number
Collect and publicly report data on workforce diversity	5001
Increase diversity among Primary Care Providers	5301
Increase diversity among long-term care providers	5302
Increase diversity among dentists	5303
Increase diversity among mental health providers	5306
Health professions training for diversity	5402
Increase diversity in nursing professions	5309
Investment in Historically Black Colleges and Universities (HBCUs) and minority-serving institutions	2104
Community-based training for Area Health Education Centers (AHECs) targeting underserved populations	5403
Grants for Community Health Workers, providing CLAS	5313
Grants to train providers on pain care, including CLAS	4305
Support for low income health profession/home care aid training	5507

Note. Adapted from *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, by D. P. Andrulis, N. J. Siddiqui, J. P Purtle, and L. Duchon, July 2010. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

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Appendix H *continued*

Six Domains of Cultural Competence Provisions of the Affordable Care Act of 2010

Table H3

Domain 3: Cultural Competence (CC) Education and Organizational Support

Affordable Care Act (ACA) Provision	ACA Section Number
Develop & evaluate model CC curricula	5307
Disseminate CC curricula through online clearinghouse	5307
CC training for primary care providers	5301
CC training for home care aides	5507
Curricula for CC in working with individuals with disabilities	5307
Loan repayment preference for experience in CC	5203
Transfer federal OMH to Office of the Secretary	10334
Create individual OMHs within federal HHS agencies 10334	10334

Note. Adapted from *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, by D. P. Andrulis, N. J. Siddiqui, J. P Purtle, and L. Duchon, July 2010. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

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Appendix H *continued*

Six Domains of Cultural Competence Provisions of the Affordable Care Act of 2010

Table H4

Domain 4: Health Disparities Research

Affordable Care Act (ACA) Provision	ACA Section Number
Patient-Centered Outcomes Research Institute (PCORI) to examine health disparities through comparative effectiveness research (CER)	6301
Increase funding to Centers of Excellence	5401
Promote the National Center on Minority Health and Health Disparities (NCMHHD) to Institute status	10334
Support collaborative research on topics including cultural competence	5307
Support for disparities research in post-partum depression	2952
Support for disparities research in pain treatment/management	4305

Note. Adapted from *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, by D. P. Andrulis, N. J. Siddiqui, J. P Purtle, and L. Duchon, July 2010. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

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Appendix H *continued*

Six Domains of Cultural Competence Provisions of the Affordable Care Act of 2010

Table H5

Domain 5: Health Disparities Initiatives Prevention

Affordable Care Act (ACA) Provision	ACA Section Number
National oral health campaign, with emphasis on disparities	4102
Standardized drug labeling on risks & benefits	3507
Maternal & child home visiting programs for at-risk communities	2951
Culturally appropriate patient-decision aids	3506
Culturally appropriate personal responsibility education	2953
Support for preventive programs for American Indians and Alaskan Natives (AI/AN)	10221

Note. Adapted from *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, by D. P. Andrulis, N. J. Siddiqui, J. P Purtle, and L. Duchon, July 2010. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

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Appendix H *continued*

Six Domains of Cultural Competence Provisions of the Affordable Care Act of 2010

Table H6

Domain 6: Addressing Disparities in Insurance Coverage

Affordable Care Act (ACA) Provision	ACA Section Number
Remove cost-sharing for AI/ANs at or below 300% of the federal poverty level (FPL)	2901
Enrollment outreach targeting low income populations	3306
CLAS/information through exchanges	1311
Nondiscrimination in federal health programs and exchanges	1557
Require plans to provide information in "plain language"	1303
Incentive payments for reducing health/healthcare disparities	1303
Summary of coverage that is culturally/linguistically appropriate	1001
Claims appeal process that is culturally/linguistically appropriate	1001

Note. Adapted from *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, by D. P. Andrulis, N. J. Siddiqui, J. P Purtle, and L. Duchon, July 2010. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

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Appendix I

The Joint Commission's Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care across the Continuum of Care

Admission

- ☐ Inform patients of their rights.
- ☐ Identify the patient's preferred language for discussing health care.
- ☐ Identify whether the patient has a sensory or communication need.
- ☐ Determine whether the patient needs assistance completing admission forms.
- ☐ Collect patient race and ethnicity data in the medical record.
- ☐ Identify if the patient uses any assistive devices.
- ☐ Ask the patient if there are any additional needs that may affect his or her care.
- ☐ Communicate information about unique patient needs to the care team.

Assessment

- ☐ Identify and address patient communication needs during assessment.
- ☐ Begin the patient–provider relationship with an introduction.
- ☐ Support the patient's ability to understand and act on health information.
- ☐ Identify and address patient mobility needs during assessment.
- ☐ Identify patient cultural, religious, or spiritual beliefs or practices that influence care.
- ☐ Identify patient dietary needs or restrictions that affect care.
- ☐ Ask the patient to identify a support person.
- ☐ Communicate information about unique patient needs to the care team.

Treatment

- ☐ Address patient communication needs during treatment.
- ☐ Monitor changes in the patient's communication status.
- ☐ Involve patients and families in the care process.
- ☐ Tailor the informed consent process to meet patient needs.
- ☐ Provide patient education that meets patient needs.
- ☐ Address patient mobility needs during treatment.
- ☐ Accommodate patient cultural, religious, or spiritual beliefs and practices.
- ☐ Monitor changes in dietary needs or restrictions that may impact the patient's care.
- ☐ Ask the patient to choose a support person if one is not already identified.
- ☐ Communicate information about unique patient needs to the care team.

End-of-Life Care

- ☐ Address patient communication needs during end-of-life care.
- ☐ Monitor changes in the patient's communication status during end-of-life care.
- ☐ Involve the patient's surrogate decision-maker and family in end-of-life care.
- ☐ Address patient mobility needs during end-of-life care.
- ☐ Identify patient cultural, religious, or spiritual beliefs and practices at the end of life.
- ☐ Make sure the patient has access to his or her chosen support person.

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Appendix I *continued*

The Joint Commission's Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care across the Care Continuum

Discharge and Transfer

- Address patient communication needs during discharge and transfer.
- Engage patients and families in discharge and transfer planning and instruction.
- Provide discharge instruction that meets patient needs
- Identify follow-up providers that can meet unique patient needs.

Organization Readiness

Leadership

- Demonstrate leadership commitment to effective communication, cultural competence, and patient- and family-centered care.
- Integrate unique patient needs into new or existing hospital policies.

Data Collection and Use

- Conduct a baseline assessment of the hospital's efforts to meet unique patient needs.
- Use available population-level demographic data to help determine the needs of the surrounding community.
- Develop a system to collect patient-level race and ethnicity information.
- Develop a system to collect patient language information.
- Make sure the hospital has a process to collect additional patient-level information.

Workforce

- Target recruitment efforts to increase the pool of diverse and bilingual candidates.
- Ensure the competency of individuals providing language services.
- Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.
- Identify staff concerns or suggested improvements for providing care that meets unique patient needs.

Provision of Care, Treatment, and Services

- Create an environment that is inclusive of all patients.
- Develop a system to provide language services.
- Address the communication needs of patients with sensory or communication impairments.
- Integrate health literacy strategies into patient discussions and materials.
- Incorporate cultural competence and patient- and family-centered care concepts into care delivery.

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Appendix I *continued*

The Joint Commission's Checklist to Improve
Effective Communication, Cultural Competence, and Patient- and Family-Centered Care across the Care Continuum

Patient, Family, and Community Engagement

- ☐ Collect feedback from patients, families, and the surrounding community.
- ☐ Share information with the surrounding community about the hospital's efforts to meet unique patient needs.

Source: *Note*. Adapted from *Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care: A Roadmap for Hospitals* by The Joint Commission, 2010. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf.

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Appendix J

ACGME Competencies
Excerpted from Section IV.A.5 of the ACGME Common Program Requirements
Effective July 1, 2011

ACGME Competencies
The program must integrate the following ACGME competencies into the curriculum:

- **Patient Care**
  Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

- **Medical Knowledge**
  Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

- **Practice-based Learning and Improvement**
  Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:
  - identify strengths, deficiencies, and limits in one's knowledge and expertise;
  - set learning and improvement goals;
  - identify and perform appropriate learning activities;
  - systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
  - incorporate formative evaluation feedback into daily practice;
  - locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
  - use information technology to optimize learning; and,
  - participate in the education of patients, families, students, residents and other health professionals.

continued

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Appendix J *continued*

ACGME Competencies
Excerpted from Section IV.A.5 of the ACGME Common Program Requirements
Effective July 1, 2011

- **Interpersonal and Communication Skills**
  Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:
    - communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
    - communicate effectively with physicians, other health professionals, and health related agencies;
    - work effectively as a member or leader of a health care team or other professional group;
    - act in a consultative role to other physicians and health professionals; and,
    - maintain comprehensive, timely, and legible medical records, if applicable.

- **Professionalism**
  Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
    - compassion, integrity, and respect for others;
    - responsiveness to patient needs that supersedes self-interest;
    - respect for patient privacy and autonomy;
    - accountability to patients, society and the profession; and,
    - sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

- **Systems-based Practice**
  Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:
    - work effectively in various health care delivery settings and systems relevant to their clinical specialty;
    - coordinate patient care within the health care system relevant to their clinical specialty;

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Appendix J *continued*

ACGME Competencies
Excerpted from Section IV.A.5 of the ACGME Common Program Requirements
Effective July 1, 2011

- incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- advocate for quality patient care and optimal patient care systems;
- work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- participate in identifying system errors and implementing potential systems solutions.

Source: Excerpted and adapted from *Common Program Requirements* [Accreditation standards] by the Accreditation Council for Graduate Medical Education, 2011. Retrieved from http://www.acgme.org/acgmeweb/Portals/0/dh_dutyhoursCommonPR07012007.pdf.

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Appendix K

Institute of Medicine Core Competencies

Provide patient-centered care
Identify, respect, and care about patients' differences, values, preferences, and expressed needs; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

Work in interdisciplinary teams
Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.

Employ evidence-based practice
Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.

Apply quality improvement
Identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care, with the objective of improving quality.

Utilize informatics
Communicate, manage knowledge, mitigate error, and support decision making using information technology.

Source: Adapted from *Health Professions Education: A Bridge to Quality* by the Institute of Medicine, 2003. Retrieved fromhttp://www.nap.edu/openbook.php?record_id=10681&page=R1.

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Appendix L

Cultural Competence Excerpt of the AMA Policy Compendium on Issues Relating to Minority Health and Minority Physicians

D-150.993 Obesity and Culturally Competent Dietary and Nutritional Guidelines
Our AMA and its Minority Affairs Consortium will study and recommend improvements to the US Department of Agriculture's Dietary Guidelines for Americans and Food Guide Pyramid so these resources fully incorporate cultural and socioeconomic considerations as well as racial and ethnic health disparity information in order to reduce obesity rates in the minority community, and report its findings and recommendations to the AMA House of Delegates by the 2004 Annual Meeting. (Res. 428, A-03)

D-440.978 Culturally Responsive Dietary and Nutritional Guidelines
Our AMA and its Minority Affairs Consortium will: (1) encourage the United States Department of Agriculture (USDA) Food Guide Pyramid Reassessment Team to include culturally effective guidelines that include listing an array of ethnic staples and use multicultural symbols to depict serving size in their revised Dietary Guidelines for Americans and Food Guide Pyramid; (2) seek ways to assist physicians with applying the final USDA Dietary Guidelines for Americans and Food Guide Pyramid in their practices as appropriate; and (3) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (BOT Rep. 6, A-04)4

H-295.874 Educating Medical Students for Cultural Competence: What do we know?
Our AMA recommends studying the integration of cultural competence training in graduate and continuing medical education and publicizing successful models. (CME Rep. 11, A-06)

H-295.897 Enhancing the Cultural Competence of Physicians
The AMA will: (1) continue to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula; (2) continue research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings; (3) form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database; (4) assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; and (5) seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review

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Appendix L *continued*

Cultural Competence Excerpt of the AMA Policy Compendium on Issues Relating to Minority Health and Minority Physicians

and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. (CME Rep. 5, A-98)

H-295.905 Promoting Culturally Competent Health Care
The AMA encourages medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (Res. 306, A-97)

H-350.965 Culturally Effective Health Care
Our AMA renews its commitment to supporting the importance of culturally effective health care in eliminating disparities and to exploring ways to provide physicians with tools for improving the cultural effectiveness of their practices. (Res. 718, I-02)

H-480.963 Folk Remedies among Ethnic Subgroups
The AMA: (1) does not recommend the sole use of invalidated folk remedies to treat disease without scientific evidence regarding their safety or efficacy; (2) encourages research to determine the safety and efficacy of folk remedies; (3) physicians should be aware that the use of folk remedies may delay patients from seeking medical attention or receiving conventional therapies with proven benefit for disease treatment and prevention; (4) practicing physicians should routinely ask patients whether they are using folk medicine or family remedies for their symptoms. Physicians can educate patients about the level of scientific information available about the therapy they are using, as well as conventional therapies that are known to be safe and efficacious; and (5) physicians should be aware of folk remedies in use and the level of scientific information available about such remedies, and should include this information when discussing conventional treatments and therapies with their patients. (CSA Rep. 13, A-97)

Source: Adapted from *American Medical Association Minority Affairs Section: Policy compendium* [Policy excerpts] by the American Medical Association, 2012. Retrieved from http://www.ama-assn.org/resources/doc/mas/policy-compendium.pdf.

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Appendix M

The American Academy of Family Physicians' Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities

Introduction

Regarding the importance of improving cultural competence in the delivery of care, the AAFP policy position states:

- The American Academy of Family Physicians (AAFP) is committed to ensuring high quality of care and patient safety by promoting access for limited English proficient (LEP) patients, cultural proficiency, expanded health workforce diversity, and reduced health disparities in the provision of medical care to our nation's LEP and racial/ethnic medically-underserved populations. Cultural proficiency is a necessary component for patient safety and adherence. All persons, regardless of race, ethnicity or primary language deserve access to high quality health services.
- Cultural proficiency is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among health professionals that enables work in cross-cultural situations. A culturally proficient organization values diversity; conducts cultural assessments; is conscious of and manages the dynamics of difference; institutionalizes cultural knowledge; and adapts services to fit the cultural diversity of the community it serves.

Organizing Principles

Regarding the education of physicians, the AAFP policy position states:

- Medical societies and health professional associations should work with their members to educate them about cultural proficiency, health disparities among racial/ethnic medically underserved populations, and the impact on health outcomes of limited English proficiency. These organizations should link to available information, training, and other resources so that health professionals may continually improve access to quality care and reduce health and health care disparities.
- Health professionals should be aware of, and sensitive to, the cultural and ethnic diversity of patients they serve so they can develop and implement best practices such as providing interpreter services and culturally proficient care in their offices. Health professionals should be aware of the connection between good cross-cultural communication and ensuring patient safety.
- The Office for Civil Rights should disseminate information and provide technical assistance about best practices in the provision of culturally, ethnically, and linguistically sensitive care delivery.

Regarding the health care workforce, the AAFP policy position states:

- The AAFP should advocate for the federal government to encourage the racial, ethnic, religious, and linguistic diversity of the health care workforce to reflect the needs of the population.

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Appendix M *continued*

The American Academy of Family Physicians' Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities

- Medical and other health professional schools should increase efforts to recruit and retain minority faculty and promote minority faculty into leadership positions.
- Cultural proficiency training should be incorporated into medical schools and residency education in every specialty and should be available as part of the continuing professional development of health professionals.
- To meet the needs of LEP patients, the federal government should provide incentives for the development of a trained interpreter workforce.
- Medical school admissions policies should reflect the importance of increasing the representation of underrepresented minority students and encourage the use of "pipeline" recruitment programs.

Regarding language access, the AAFP policy position states:

- Language assistance services, including, but not limited to, qualified bilingual health professionals, trained health care interpreters, telephonic and video language services, translated or in-language written materials, and translated or in-language signage, are an essential element of delivering culturally proficient care in all settings, particularly to LEP and racial/ethnic medically-underserved communities.
- Any language access requirements placed on health professionals must recognize the logistical difficulties in the provision of interpreter services for unusual or rarely encountered languages and in urgent and emergent situations, and provide exemptions and additional assistance for these situations, as appropriate.
- National, state, regional, and local systems of language assistance service should take into account the limited capabilities and resources of health plans, hospitals, clinics, health departments, medical groups, physician practices, and other health professionals. To the extent possible, there should be efforts to collaborate, coordinate, and centralize the provision of language assistance services to increase efficiencies and minimize costs and administrative burdens to health professionals.
- Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity.

Regarding research and data collection, the AAFP policy position states:

- Health insurers and health care plans should be encouraged to collect and/or report socio-cultural health information (e.g., patient race and ethnicity, including subpopulations, primary language, etc.) to assist physician offices, while respecting the individual privacy of patients. This data collection shall not be delegated to the treating physician without an explicit paid, contractual agreement.

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Appendix M *continued*

The American Academy of Family Physicians' Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities

- Culturally and ethnically diverse populations should be fully represented as appropriate in clinical studies supported by both private and public sector funds. Encourage researchers from minority communities to conduct research and clinical trials.
- Diseases and conditions disproportionately affecting LEP and racial and ethnic medically-underserved populations should be adequately investigated. Research on specific populations should be conducted to document health issues and successful interventions. This research goal can be accomplished through the Institutional Review Board process and through research done by Practice-Based Research Networks.

Regarding access to health care services, the AAFP policy position states:

- The availability of, and access to, quality, affordable health services are integral to eliminating disparities among LEP and racial/ethnic medically-underserved populations.
- Public insurance programs should promote access for beneficiaries by advertising availability, providing applications and other documents in other languages, and reviewing application processes to see what barriers may exist for eligible populations.

Regarding written sources of information, the AAFP policy position states:

- National, state and other interested stakeholders should examine the feasibility of clearinghouses for translated or in-language materials that could increase access to quality health education, medication information, and other health-related information.

Regarding the assessment of cultural competence measures, the AAFP policy position states:

- Quality indicators that measure cultural proficiency should be developed.
- A review of current quality assessment measures should be conducted to identify areas for integration of cultural proficiency measures and make appropriate recommendations.

Regarding the payment of interpreters, the AAFP policy position states:

- Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity.
- The primary financial entity (state, insurance company, or managed care company) should contract with and pay interpreters directly unless medical groups or physicians explicitly choose to accept risk for such services in their contracts. Health professionals, including medical groups, should not unwillingly bear the burden or expense of providing interpreter services.

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Appendix M *continued*

The American Academy of Family Physicians' Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities

- There should be consideration of reimbursement of physician office bilingual staff who serves as interpreters, as long as they have been trained and assessed for linguistic competency.
- There should be consideration of compensation for bilingual physicians who would otherwise require an interpreter, provided they have been assessed for linguistic competency.

Policy Options

Regarding Medicaid, State Health Insurance Programs (SHIP), and Medicare, the AAFP position states:

- The federal government should work with the Centers for Medicare and Medicaid Services (CMS) and the State Health Insurance Programs (SHIPs) to ensure the cultural and linguistic proficiency of their respective staffs. Materials used to detail Medicare services, in particular Medicare-covered preventive care, should meet the language and health literacy levels of the beneficiaries they serve. CMS should evaluate the materials and strategies used by SHIPs to reach the LEP and racial/ethnic populations they serve.
- The federal government should work with CMS to ensure that reliable and comprehensive data are collected and reported with regard to beneficiaries' race, ethnicity, educational level, and primary language, while respecting the individual privacy rights of beneficiaries.
- The federal government should work with CMS to ensure that any program developed by CMS that bases a payment, bonus or reward on quality measures, includes quality measures of care for minority beneficiaries.
- The federal government should seek federal matching funds for the provision of interpreter services for patients in the Medicaid and SHIP programs; state governments should also address funding issues within the workers' compensation programs.
- The AAFP should work with federal policy makers and private health insurance stakeholders to ensure that language services are a covered benefit under the Medicare program and private insurance programs.
- The AAFP should advocate for a centralized service for interpretation that can be accessed easily by physicians. Models with significant promise include those in place in Washington State and the national telephonic interpreting service in Australia. The AAFP should support a regional pilot project to test delivery models for such a service.

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Appendix M *continued*

The American Academy of Family Physicians' Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities

Regarding managed care and/or health plan organizations, the AAFP policy position states:

- Managed care/health plan organizations, including public and private Health Maintenance Organizations (HMOs), should work with physician and other health professional organizations to ensure the development, evaluation, and diffusion of curricula, training, and education programs that address cultural proficiency, medically underserved communities, and health disparities.
- Managed care/health plan organizations and health plan regulators should use cultural proficiency and the provision of high quality, easily accessed language services, as indicators of access and quality.
- Both public and private HMOs and health plans should be asked to take explicit responsibility for paying and arranging for interpreter services as a covered benefit for members with the caveat that such services are the responsibility of the primary financial entity (HMO or purchaser) and are not to be born[e] [sic.] by fiscal intermediaries such as local medical groups or physicians and other health professionals, unless they have explicitly contracted for the provision of such interpreter services.
- Managed care/health plan organizations should negotiate with both public and private payers for adequate reimbursement or direct payment to cover the expenses of interpreter services so that they can establish services without burdening physicians.
- Private industry should be engaged by medical organizations, including the AAFP, and patient advocacy groups to consider innovative ways to provide interpreter services to both employees and the medically underserved.

Source: Adapted from *Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities* [Position paper] by the American Academy of Family Physicians, 2008. Retrieved from http://www.aafp.org/online/en/home/policy/policies/p/princcultuproficcare.html.

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Appendix N

American College of Physicians 2010 Cultural Competence Policy Positions

Position No.	Description
Position 1	Providing all legal residents with affordable health insurance is an essential part of eliminating racial and ethnic disparities in health care.
Position 2	All patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high-quality health care.
Position 3	As our society increasingly becomes racially and ethnically diverse, physicians and other health care professionals need to acknowledge the cultural, informational, and linguistic needs of their patients. Health literacy among racial and ethnic minorities must be strengthened in a culturally and linguistically sensitive manner.
Position 4	Physicians and other health care professionals must be sensitive to cultural diversity among patients and recognize that preconceived perceptions of minority patients may play a role in their treatment and contribute to disparities in health care among racial and ethnic minorities. Such initiatives as cultural competency training should be incorporated into medical school curriculae to improve cultural awareness and sensitivity.
Position 5	The health care delivery system must be reformed to ensure that patient-centered medical care is easily accessible to racial and ethnic minorities and physicians are enabled with the resources to deliver quality care.
Position 6	A diverse health care workforce that is more representative of the patients it serves is crucial to promote understanding among physicians and other health care professionals and patients, facilitate quality care, and promote equity in the health care system. A. Education of minority students at all educational levels, especially in the fields of math and science, needs to be strengthened and enhanced to create a larger pool of qualified minority applicants for medical school. B. Medical and other health professional schools should revitalize efforts to improve matriculation and graduation rates of minority students. ACP supports policies that allow institutions of higher education to consider a person's race and ethnicity as one factor in determining admission in order to counter the impact of current discriminatory practices and the legacy of past discrimination practices. Programs that provide outreach to encourage minority enrollment in medical and health professional schools should be maintained, reinstated, and expanded. C. Medical schools need to increase efforts to recruit and retain minority faculty. D. Efforts should be made to hire and promote minorities in leadership positions in all arenas of the health care workforce.

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Appendix N continued

American College of Physicians 2010 Cultural Competence Policy Positions

Position No.	Description
Position 6	Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals in minority communities.
Position 7	Social determinants of health are a significant source of health disparities among racial and ethnic minorities. Inequities in education, housing, job security, and environmental health must be erased if health disparities are to be effectively addressed.
Position 8	Efforts must be made to reduce the effect of environmental stressors that disproportionately threaten to harm the health and well-being of racial and ethnic communities.
Position 9	More research and data collection related to racial and ethnic health disparities is needed to empower stakeholders to better understand and address the problem of disparities.

Note. Adapted from *Racial and ethnic disparities in health care, updated 2010* [Policy paper] by American College of Physicians, 2010. Retrieved from http://www.acponline.org/advocacy/where_we_stand/access/racial_disparities.pdf.

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Appendix O

The AAMC's Tool for Assessing Cultural Competence Training (TACCT) Content Domains

<u>Domain I: Cultural Competence—Rationale, Context, and Definition</u>

A. Definition and understanding of the importance of cultural competence; how cultural issues affect health and health-care quality and cost; and, the consequences of cultural issues
B. Definitions of race, ethnicity, and culture, including the culture of medicine
C. Clinicians' self-assessment, reflection, and self-awareness of own culture, assumptions, stereotypes, biases

<u>Domain II: Key Aspects of Cultural Competence</u>

A. Epidemiology of population health
B. Patient/family-centered vs. physician-centered care: emphasis on patients'/families' healing traditions and beliefs [for example, ethno-medical healers]
C. Institutional cultural issues
D. Information on the history of the patient and his/her community of people

<u>Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making</u>

A. History of stereotyping, including limited access to health care and education
B. Bias, stereotyping, discrimination, and racism
C. Effects of stereotyping on medical decision-making

<u>Domain IV: Health Disparities and Factors Influencing Health</u>

A. History of health-care design and discrimination
B. Epidemiology of specific health and health-care disparities
C. Factors underlying health and health-care disparities—access, socioeconomic, environment, institutional, racial/ethnic
D. Demographic patterns of health-care disparities, both local and national
E. Collaborating with communities to eliminate disparities—through community experiences

<u>Domain V: Cross-Cultural Clinical Skills</u>

A. Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class
B. Dealing with hostility/discomfort as a result of cultural discord
C. Eliciting a culturally valid social and medical history
D. Communication, interaction, and interviewing skills
E. Understanding language barriers and working with interpreters
F. Negotiating and problem-solving skills
G. Diagnosis, management, and patient-adherence skills leading to patient compliance

Source: *Cultural Competence Education for Medical Students* [Educational standards] by the Association of American Medical Colleges, 2005. Retrieved from https://www.aamc.org/download/54338/data/.

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Appendix P

Knowledge (K), Skills (S), and Attitudes (A) to be Associated with the Five TACCT Domains

Domain I: Cultural Competence—Rationale, Context, and Definition

At the end of medical school, students will:

K1. Define—in contemporary terms—race, ethnicity, and culture, and their implications in health care.
K2. Identify how these factors—race, ethnicity, and culture—affect health and health-care quality, cost, and consequences.
K3. Identify patterns of national data on health, health-care disparities, and quality of healthcare.
K4. Describe national health data in a worldwide immigration context.
S1. Discuss race, ethnicity, and culture in the context of the medical interview and healthcare.
S2. Use self-assessment tools, asking:
What is my culture? What are my assumptions/stereotypes/biases?
S3. Use Healthy People 2010 and other resources to make concrete the epidemiology of health-care disparities.
A1. Describe their own cultural background and biases.
A2. Value the importance of the link between effective communication and quality care.
A3. Value the importance of diversity in health care and address the challenges and opportunities it poses.

Domain II: Key Aspects of Cultural Competence

At the end of medical school, students will:

K1. Describe historical models of common health beliefs and health belief models (for example, illness in the context of "hot and cold," Galen and other cultures).
K2. Recognize patients'/families' healing traditions and beliefs, including ethno-medical beliefs.
K3. Describe common challenges in cross-cultural communication (for example, trust, style).
K4. Demonstrate basic knowledge of epidemiology and biostatistics.
K5. Describe factors that contribute to variability in population health.
S1. Outline a framework to assess communities according to population health criteria, social mores, cultural beliefs, and needs.
S2. Ask questions to elicit patient preferences and respond appropriately to patient feedback about key cross-cultural issues. Elicit additional information about ethno-medical conditions and ethno-medical healers.
S3. Elicit information from patient in context of family-centered care.
S4. Collaborate with communities to address community needs.
S5. Recognize and describe institutional cultural issues.
A1. Exhibit comfort when conversing with patients/colleagues about cultural issues.
A2. Ask questions and listen to patients discuss their health beliefs in a nonjudgmental manner.
A3. Value the importance of social determinants and community factors on health and strive to address them.
A4. Value the importance of curiosity, empathy, and respect in patient care.

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Appendix P *continued*

Knowledge (K), Skills (S), and Attitudes (A) to be Associated with the Five TACCT Domains

Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making
At the end of medical school, students will:

K1. Describe social cognitive factors and impact of race/ethnicity, culture, and class on clinical decision-making.
K2. Identify how physician bias and stereotyping can affect interaction with patients, families, communities, and other members of the health-care team.
K3. Recognize physicians' own potential for biases and unavoidable stereotyping in a clinical encounter.
K4. Describe the inherent power imbalance between physician and patient and how it affects the clinical encounter.
K5. Describe patterns of health-care disparities that can result, at least in part, from physician bias.
K6. Describe strategies for partnering with community activists to eliminate racism and other bias from health care.
S1. Demonstrate strategies to assess, manage, and reduce bias and its effects in the clinical encounter.
S2. Describe strategies for reducing physician's own biases.
S3. Demonstrate strategies for addressing bias and stereotyping in others.
S4. Engage in reflection about their own cultural beliefs and practices.
S5. Use reflective practices in patient care.
S6. Gather and use local data as examples of Healthy People 2010.
A1. Identify their own stereotypes and biases that may affect clinical encounters.
A2. Recognize how physician biases impact the quality of health care.
A3. Describe/model potential ways to address bias in the clinical setting.
A4. Recognize importance of bias and stereotyping on clinical decision-making.
A5. Recognize need to address personal susceptibility to bias and stereotyping.

Domain IV: Health Disparities and Factors Influencing Health
At the end of medical school, students will:

K1. Describe factors other than bio-medical—such as access, historical, political, environmental, and institutional—that impact health and underlie health and health-care disparities.
K2. Discuss social determinants on health including, but not limited to, the impact of education, culture, socioeconomic status, housing, and employment.
K3. Describe systemic and medical-encounter issues, including communication, clinical decision-making and patient preferences.
K4. Identify and discuss key areas of disparities described in Healthy People 2010 and the Institute of Medicine's Report, Unequal Treatment.
K5. Describe important elements involved in community-based experiences.
K6. Discuss barriers to eliminating health disparities.

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Appendix P *continued*

Knowledge (K), Skills (S), and Attitudes (A) to be Associated with the Five TACCT Domains

S1. Critically appraise the literature as it relates to health disparities, including systems issues and quality in health care.
S2. Describe methods to identify key community leaders.
S3. Develop a proposal for a community-based health intervention.
S4. Actively strategize ways to counteract bias in clinical practice.
A1. Recognize the existence of disparities that are amenable to intervention.
A2. Realize the historical impact of racism and discrimination on health and health care.
A3. Value eliminating disparities.

Domain V: Cross-Cultural Clinical Skills
At the end of medical school, students will:

K1. Identify questions about health practices and beliefs that might be important in a specific local community.
K2. Describe models of effective cross-cultural communication, assessment, and negotiation.
K3. Understand models for physician-patient negotiation.
K4. Describe the functions of an interpreter.
K5. List effective ways of working with an interpreter.
K6. List ways to enhance patient adherence by collaborating with traditional and other community healers.
S1. Elicit a culture, social, and medical history, including a patient's health beliefs and model of their illness.
S2. Use negotiating and problem-solving skills in shared decision-making with a patient.
S3. Identify when an interpreter is needed and collaborate with interpreter effectively.
S4. Assess and enhance patient adherence based on the patient's explanatory model.
S5. Recognize and manage the impact of bias, class, and power on the clinical encounter.
A1. Demonstrate respect for a patient's cultural and health beliefs.
A2. Acknowledge their own biases and the potential impact they have on the quality of health care.

Note. Adapted from *Cultural Competence Education for Medical Students* [Educational standards] by the Association of American Medical Colleges, 2005. Retrieved from https://www.aamc.org/download/54338/data/.

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Appendix Q

Cultural Competencies Common to Medical and Public Health Students

Knowledge (Cognitive Competencies)	Skills (Practice Competencies)
At the completion of the program of study, students will be able to: ▪ Define cultural diversity including language, sexual identity, age, race, ethnicity, disability, socioeconomics, and education ▪ Differentiate health, health care, health care systems, and health disparities ▪ Identify cultural factors that contribute to overall health and wellness* ▪ Describe the influence of culture, familial history, resiliency, and genetics on health outcomes ▪ Examine factors that contribute to health disparities, particularly social, economic, environmental, health systems, and access ▪ Identify health disparities that exist at the local, state, regional, national, and global levels ▪ Recognize that cultural competence alone does not address health care disparities ▪ Describe the elements of effective communication with patients, families, communities, peers, and colleagues* ▪ Describe strategies to communicate with limited English proficient patients and communities ▪ Describe the role of community engagement in health care and wellness ▪ Assess the impact of acculturation, assimilation, and immigration on health care and wellness ▪ Articulate the role of reflection and self-assessment of cultural humility in ongoing professional growth ▪ Describe both value and limitation of evidence-based literature on understanding the health of individuals and communities ▪ Articulate roles and functions of local health departments and community partners, to include capabilities and limitations*	*At the completion of the program of study, students will be able to:* ▪ Identify one's own assets and learning needs related to cultural competence ▪ Incorporate culture as a key component of patient, family, and community history ▪ Integrate cultural perspectives of patient, family and community in developing treatment/interventions* ▪ Apply (community) constituent /patient-centered principles to earn trust and credibility ▪ Conduct culturally appropriate risk and asset assessment, management, and communication with patients and populations ▪ Contribute expertise to culturally competent interventions ▪ Communicate in a culturally competent manner with patients, families, and communities ▪ Employ self-reflection to evaluate the impact of one's practice ▪ Work in a transdisciplinary setting/team ▪ Demonstrate shared decision making ▪ Analyze illness conditions and health outcomes of concern at the patient and community levels ▪ Engage community partners in actions that promote a healthy environment and healthy behaviors ▪ Communicate with colleagues, patients, families, and communities about health disparities and health care disparities ▪ Establish equitable partnerships with local health departments, faith and community-based organizations, and leaders to develop culturally appropriate outreach and interventions*

Attitudes (Values / Beliefs Competencies)
At the completion of the program of study, students will be able to: ▪ Demonstrate willingness to apply the principles of cultural competence ▪ Appreciate how cultural competence contributes to the practice of medicine and public health ▪ Appreciate that becoming culturally competent involves lifelong learning ▪ Demonstrate willingness to assess the impact of one's own culture, assumptions, stereotypes, and biases on the ability to provide culturally competent care and service ▪ Demonstrate willingness to explore cultural elements and aspects that influence decision making by patients, self, and colleagues ▪ Demonstrate willingness to collaborate to overcome linguistic and literacy challenges in the clinical and community encounter ▪ Appreciate the influence of institutional culture on learning content, style, and opportunities of professional training programs

Note. Adapted from *Cultural Competence Education for Students in Medicine and Public Health: Report of an Expert Panel* [Educational standards] by the Association of American Medical Colleges and Association of Schools of Public Health, 2012. Retrieved from https://members.aamc.org/eweb/upload/Cultural%20Competence%20Education_revisedl.pdf. *Denotes competencies which bridge more than one of the AAMC and ASPH 3 three identified domains of cultural competence: Knowledge, Skills, and/or Attitudes (KSA's)

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Appendix R

Mapping AAMC and ASPH Joint Cultural Competencies to ACGME Core Competencies

ACGME Core Competency	AAMC and ASPH Joint Cultural Competencies
Patient Care Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.	Patient Care ▪ Incorporate culture as a key component of patient, family, and community history. ▪ Integrate a patient's/family's/community's cultural perspective(s) in developing treatment/interventions. ▪ Demonstrate shared decision making. ▪ Contribute expertise to culturally competent interventions.
Medical Knowledge Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.	Medical Knowledge ▪ Identify cultural factors that contribute to overall health and wellness. ▪ Describe the influence of culture, familial history, resiliency, and genetics on health outcomes. ▪ Describe the values and limitations of evidence-based literature on understanding the health of individuals and communities.
Practice-based Learning and Improvement Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.	Practice-Based Learning and Improvement ▪ Articulate cultural humility and its role in reflection and self-assessment. ▪ Assess the impact of acculturation, assimilation, and immigration on health care and wellness. ▪ Identify one's own assets and learning needs related to cultural competence. ▪ Employ self-reflection to evaluate the impact of one's practice. ▪ Appreciate that becoming culturally competent involves lifelong learning. ▪ Demonstrate willingness to assess the impact of one's own culture, assumptions, stereotypes, and biases on the ability to provide culturally competent care and service.
Professionalism Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.	Professionalism ▪ Articulate cultural humility, cultural diversity, and cultural competence and their roles in ongoing professional development. ▪ Appreciate how cultural competence contributes to the practice of medicine and public health. ▪ Demonstrate willingness to explore cultural elements and aspects that influence decision making by patients, self, and colleagues. ▪ Appreciate the influence of institutional culture on learning content, style, and opportunities of professional training programs.

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Appendix R *continued*

Mapping AAMC and ASPH Joint Cultural Competencies to ACGME Health Care Core Competencies

ACGME Core Competency	AAMC and ASPH Joint Cultural Competencies
Systems-based Practice Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.	Systems-based Practice ▪ Differentiate health, health care, health care systems, and health disparities. ▪ Examine factors that contribute to health disparities, particularly social, economic, environmental, health systems, and access to quality health care. ▪ Describe the role of community engagement in health care and wellness. ▪ Identify health disparities that exist at the local, state, regional, national, and global levels. ▪ Articulate the roles and functions of local health departments, community partners and organizations, to include capabilities and limitations. ▪ Conduct culturally appropriate risk and asset assessment, management, and communication with patients and populations. ▪ Work in a trans-disciplinary setting/team. ▪ Analyze illness conditions and health outcomes of concern at the patient and community levels. ▪ Engage community partners in actions that promote a healthy environment and healthy behaviors. ▪ Establish equitable partnerships with local health departments, faith and community-based organizations, and leaders to develop culturally appropriate outreach and interventions. ▪ Recognize that cultural competence alone does not address health care disparities.

Note. Adapted from *Cultural Competence Education for Students in Medicine and Public Health: Report of an Expert Panel* [Educational standards] by the Association of American Medical Colleges and Association of Schools of Public Health, 2012. Retrieved from https://members.aamc.org/eweb/upload/Cultural%20Competence%20Education_revisedl.pdf and the *Common Program Requirements* [Accreditation standards] by the Accreditation Council for Graduate Medical Education, 2011. Retrieved from http://www.acgme.org/acgmeweb/Portals/0/dh_dutyhoursCommonPR07012007.pdf.

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