Delivering Culturally Competent Care in Clinical Practice: A Call to Action

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Keywords: cultural competence ■ race/ethnicity ■ minority health

J Natl Med Assoc. 2012;104:104-107

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INTRODUCTION

Minority populations in the United States are growing rapidly. Based on 2006 data from the US Census Bureau, minorities currently represent 25% of the US population. Trends indicate that this percentage will increase and that by 2050 up to half of the population will consist of people who have historically been called minorities.[1] This shift in the composition of the population represents a significant challenge for health care providers (HCPs) across the nation, as disparities in health care are already present in the United States and minorities are less likely than whites to receive needed services across a number of chronic disease states, including cancer, cardiovascular disease, HIV/AIDS, renal disease, diabetes, and mental illness.[2]

Some of this disparity can be accounted for by health care access limitations related to insurance coverage because higher percentages of minorities than whites rely on public insurance or have no insurance coverage at all. In a recent study of nonelderly patients, 74.4% of non-Hispanic whites had private insurance, compared with just 68.4% of Asians/South Pacific Islanders, 49.7% of non-Hispanic blacks, 43.9% of American Indians/Alaska Natives, and 41.7% of Hispanics. At the same time, 32.2% of Hispanics, 27.9% of American Indians/Alaska Natives, 20.6% of non-Hispanic blacks, and 18.7% of Asians/South Pacific Islanders had no insurance coverage, compared with just 12.7% of whites.[3] However, not all of the health disparities in the United States can be accounted for by lack of access to services. The quality of the care that racial and ethnic minorities receive also has a significant impact on their health outcomes. The growth of underserved multicultural populations with a high rate of chronic disease underscores the need for HCPs who are culturally competent in delivering their care.

The American Medical Association (AMA) defines *cultural competency* in terms of both awareness and acceptance of differences in the behavior patterns, beliefs, arts, and other products of a particular community.[4] In order to execute culturally competent care, HCPs need to have the knowledge and interpersonal skills to understand, appreciate, and work with individuals from cultures other than their own. They also need an awareness and acceptance of cultural differences, self-awareness, knowledge of the patient's culture, and adaptation skills.[4]

PREVALENCE OF CHRONIC ILLNESSES AMONG RACIAL/ETHNIC MINORITIES

In the United States, the burden of chronic illness is greatest among racial/ethnic minority groups, and trends indicate that rates of chronic disease will continue to grow in the future. For example, the Centers for Disease Control estimate that 4.9 million non-Hispanic blacks are affected by diabetes. This number amounts to 18.7% of the total population of non-Hispanic blacks aged greater than 20 years in the country.[5] Indeed, spending on diabetes care is predicted to increase dramatically in the next 20 years.[6] Furthermore, while the number of non-Hispanic whites with diabetes is expected to decrease by more than half when the new definition of *diabetes*, based on HbA_{1c} (instead of fasting plasma glucose), is put into place, no impact on rates of diabetes in minority communities is anticipated.[7]

Both chronic kidney disease (CKD) and end-stage renal disease (ESRD) are also more common in African Americans and Hispanic Americans than in non-Hispanic white persons. African Americans with CKD are 4 times more likely to progress to ESRD than are whites (988 vs 254 patients per million). Similarly, the risk for ESRD is almost 2 times higher for Hispanic individuals and 1.34 times higher for Asians/Pacific Islanders than for whites. Prevalence of ESRD is also 2.3 times greater in American Indians/Native Americans than in non-Hispanic whites.[8] Racial disparities are also evident in the outcome of kidney transplantation for patients with CKD. African American patients have a 1.38 times' higher risk than do other patients for death after kidney transplant and are twice as likely to lose the kidney graft due to rejection.[9]

Widespread disparities in heart disease and related

risk factors are also present among minorities in the United States. For example, cardiovascular disease and high blood pressure are more prevalent in American Indians than in any other racial/ethnic group in the United States.[1] In addition, African Americans, Hispanics/Latinos, American Indians/Alaska Natives, and Asians/Pacific Islanders are all more likely than whites to suffer premature death from heart disease.[10] To exacerbate this problem, knowledge of risk factors associated with coronary heart disease is often low in at-risk minority populations, particularly South Asians.[11]

Health disparities are also evident in cancer. For example, nearly all minorities assessed in a recent study had a higher rate of stage IV breast cancer and breast cancer–related mortality than did non-Hispanic whites.[12] In fact, minorities have significantly higher burden rates than whites for most malignancies, a trend that has been increasing. The largest increase in cancer burden trend rate has been noted in American Indians/Alaskan Natives. Importantly, for some types of cancer, minorities with the highest socioeconomic status (SES) had worse trend results than the lowest-SES white group.[13] This finding suggests that the differences in cancer burden rates are related to other factors beyond access to health care services.

SOURCES OF DISPARITIES IN HEALTH CARE

Disparities in health care for minorities exist at 3 levels: the patient, the provider, and the health system (Figure).[2] Patient-level factors include treatment preferences; differences in response to treatment; and differences in care-seeking behavior, including treatment refusal. For example, some studies have shown that African Americans are more likely than other groups to reject medical recommendations. Minority patients also perceive higher levels of racial discrimination in health care than do nonminority patients.[2]

At the provider level, potential factors contributing to disparities include bias (or prejudice) against minorities, greater clinical uncertainties when treating minority patients, and beliefs or stereotypes about the health or behavior of minorities. Physicians may act on stereotypes that can influence interactions and shape expectations when treating multicultural patients. These biases based on race or ethnicity can influence an HCP's diagnostic and treatment decisions. To compound the problem, HCPs may not even realize that they are being influenced by these prejudices.[2]

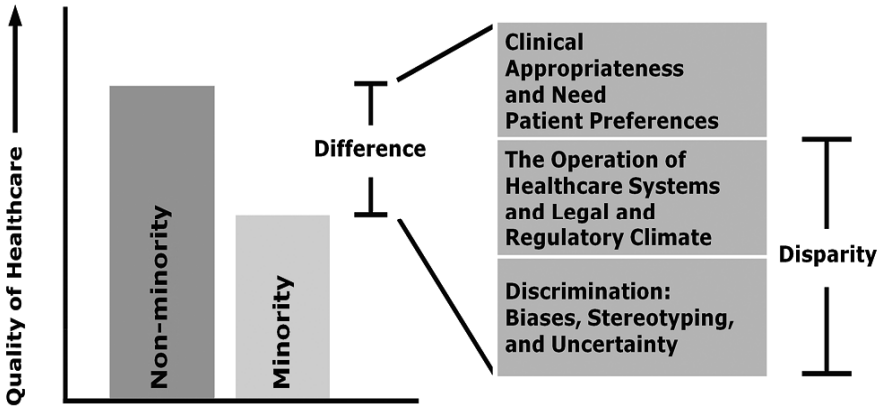
Factors related to the operation of the health care system also contribute to health disparities in the United States, including the lack of interpretation and translation services, the geographic availability of health care institutions, time pressures on physicians, and changes in the financing and delivery of health care services (such as incentives to physicians to limit services).[2] As described above, access to health care services is frequently limited or unavailable for minority patients.[3] These factors can combine to limit the effectiveness of HCPs when treating multicultural patients.

Some encouragement can be found in the fact that the quality of health care in the United States is slowly improving. Unfortunately, at the same time, disparities in health show little evidence of narrowing. Fewer than 20% of the disparities identified among African Americans, American Indians/Alaska Natives, and Hispanics demonstrated any improvement in a recent assessment. Furthermore, almost no improvements in access to health care for minorities have been noted, with Hispanics being the least likely racial/ethnic group to have health insurance.[14]

NEED FOR CULTURAL COMPETENCY TRAINING

In light of these and other disparities in health care too numerous to list here, the need for culturally

Figure. Differences, Disparities, and Discrimination: Populations With Equal Access to Health Care



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competent HCPs is critical. Many programs have been instituted at the local, state, and federal levels to train HCPs in ways to increase the cultural competency of their practices. One example is the CARE Columbus program, in which 601 physicians, nurses, public health educators and program coordinators, licensed social workers, health care and human services staff, and administrators in Columbus, Ohio, underwent a training program that focused on 4 key areas[15]:

- Considering and reflecting on patients'/clients' health and cultural issues and concerns;
- Accepting and understanding that patients'/clients' cultural differences, practices, and perspectives will impact their health care experience;
- Recognizing and building familiarity with individual patient's/client's cultural norms, beliefs, and attitudes toward health care;
- Executing a proactive, culturally sensitive health care intervention that supports patients'/clients' recovery and respects their cultural values without compromising the quality of their health care and medical treatment.

Other cultural competency training initiatives have been put into place for medical residents to ensure that they are adequately equipped to treat patients from multicultural backgrounds. The US Department of Health and Human Services has been providing grant funding for resident training for many years through the Health Resources and Services Administration (HRSA). A recent survey of the results of these training programs showed that residents trained in HRSA-funded programs were more likely to have experiences in residency that were useful for treating culturally diverse patients and to report being prepared to treat multicultural patients with greater skill than their counterparts who did not undergo HRSA-funded programs.[16]

Programs like CARE Columbus and the HRSA training programs that increase the cultural competency of HCPs have been shown to reduce racial and ethnic health disparities. In one study, African American educators and patient facilitators provided culture-specific education to 83 African American patients with diabetes. Patients were educated on diabetes complications in their minority group, cultural beliefs that hinder diabetes care, recommended exercise levels, diet relevant to their ethnic cooking methods, and eating habits. Educators also made follow-up phone calls to patients and providers to monitor treatment.[17]

This type of culturally tailored care significantly improved the outcomes for these African American patients with diabetes. Compared with preintervention levels, HbA_{1c} values decreased by 2.4% from a baseline of 10.6%, with 20% of patients reaching an HbA_{1c} less than 7%. In addition, this intervention precipitated a 54% decrease in emergency room visits and a 36% reduction in hospitalizations. All of these improvements were seen without increasing the burden on physicians.[17]

The Hypertension Improvement Project Latino Pilot Study is another example of the value of a culture-specific education program. This study was designed to assess the feasibility of culturally competent behavioral interventions for Hispanic/Latino adults with high blood pressure. The intervention consisted of weekly group sessions that incorporated motivational interviewing techniques and instructions on preparing modified recipes from the regular Hispanic/Latino diet. At study end, the participants in the program showed improvements in every outcome measure except fat intake, with the largest impact on weight loss and amount of exercise as well as a 10.4-mmHg reduction in systolic blood pressure.[18] Although this was a relatively small study, the findings suggest that culturally competent interventions can improve behavior and enhance outcomes for multicultural patients with hypertension.

Another study found that a culture-specific approach was effective at increasing colorectal cancer (CRC) screening in recent Chinese immigrants to the United States. Patients in the intervention arm of the study received CRC screening education from a trilingual (English, Cantonese, and/or Mandarin) and bicultural Chinese American health educator as well as a CRC informational pamphlet and a fecal occult blood test with instructions in Chinese and English. Fecal occult blood testing was undertaken by 69.5% of patients in this group, compared with just 27.6% of patients in the control group.[19] This improvement in CRC screening rates demonstrates the importance of culturally competent interventions in cancer screening.

These are just a few examples of cases where the delivery of culturally competent care has been shown to improve outcomes for patients with a chronic disease. Other programs have been put into place using the core principles of cultural competency outlined by the AMA. These initiatives have provided many needed interventions from culture-specific diabetes education for Mexican Americans[20] to smoking cessation and prevention aids for American Indian/Alaska Native youth[21] to enhance the quality of care for multicultural patients in the United States.

In light of these successes, the Department of Health and Human Services has implemented a set of standards to enhance the delivery of culturally competent health care. These standards for culturally and linguistically appropriate services are intended to "contribute to the elimination of racial and ethnic health disparities and improve the health of all Americans."[22] Other initiatives have been put in place by several states: California, Georgia, New Jersey, New York, Ohio, and Washington have all passed or are currently considering bills requiring cultural competency training for physicians.[23]

CONCLUSIONS

Training HCPs in cultural competency is necessary to create health parity in the United States. While awareness of health disparities in minority populations is high, the challenge remains for practitioners to take action to improve the health of all Americans. There are many examples of successful cultural competency initiatives, just a few of which are described here. Hopefully, these examples of HCPs taking action to reach out to multicultural patients will inspire readers to enhance the quality of the services delivered in their practices and by their colleagues. Unless the medical community acts now, health disparities and rates of chronic disease in minority patients will continue to worsen.

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