

## The Role of Culturally Competent Communication in Reducing Ethnic and Racial Healthcare Disparities

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Promoting culturally competent communication at the provider, care institution, health plan, and national levels is likely to contribute to success in reducing racial and ethnic disparities in the receipt of high quality care. Although some health plans recently have shown interest in addressing racial and ethnic disparities in care, very few have addressed how health plans can improve their cultural competency to reduce disparities. This commentary summarizes the importance of culturally competent communication across several levels of the healthcare system and details concrete steps that managed care organizations can take to maximize their ability to provide culturally competent communication and care.

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The importance of effective patient-provider communication in delivering high-quality care is well accepted. Good patient-provider communication is associated with better patient satisfaction, better adherence to treatment recommendations, and improved health outcomes.<sup>1,2</sup> It is assumed, but not proven, that the components of communication that acknowledge and take into account differences between providers and patients—particularly with regard to culture, ethnicity, and beliefs—play an important role in efforts to reduce racial and ethnic disparities in the quality of care. Culturally competent communication refers to communicating with awareness and knowledge of healthcare disparities and understanding that socio-cultural factors have important effects on health beliefs and behaviors, as well as having the skills to manage these factors appropriately.<sup>3</sup> This issue is so important that the Institute of Medicine, in its seminal report *Unequal Treatment*, identified cross-cultural training as a key recommendation for reducing healthcare disparities.<sup>4</sup> Numerous other organizations have addressed the need to incorporate culture in the training of health professionals.<sup>5,6</sup>

When applied to healthcare, culturally competent communication is not simply an attribute of the patient-provider encounter. It also is an attribute of the healthcare institution (eg, office, clinic, hospital) and the larger system in which care is financed and delivered (eg, health plan). Promoting culturally competent communication at the provider, care institution, health plan, and national levels is likely to contribute to suc-

cess. Some health plans recently have shown interest in addressing racial and ethnic disparities in care.<sup>7</sup> However, very few have addressed how health plans can improve their cultural competency to reduce disparities.<sup>8</sup>

This Theme Issue aims not only to shed light on the broad array of factors related to racial and ethnic disparities in quality of care, but also to convey the potentially important role that cultural competence and communication play in those disparities. The 6 papers in this issue present information about the role of culture in healthcare communication that health plans and others should find useful, as well as propose mechanisms by which interventions could be developed and evaluated. The issue includes work from 2 important conferences.

The first meeting was the Conference on Diversity and Communication in Health Care: Addressing Race/Ethnicity, Language, and Social Class in Health Care Disparities, which was held in February 2000. This was the first national gathering of experts in patient-provider communication, cultural competency, health disparities, and health professional training, and was convened as part of a federal response to Schulman et al's 1999 study, which pinpointed the patient-doctor interaction as a potential source of disparity in quality.<sup>9</sup> It was sponsored by the Office of Minority Health in the US Department of Health and Human Services, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, The Commonwealth Fund, and the Sergei Zlinkoff Fund for Medical Education and Research.

Four papers from this conference are included in this issue. Zambrana and her coauthors expressly examine the intersections of race, ethnicity, socioeconomic status, and culture within managed care systems.<sup>10</sup> Horner and colleagues describe the results of an expert panel's efforts to identify strategies for improving healthcare

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providers' cultural competency.<sup>11</sup> de Bocanegra and Gany, in a review of the literature, examine the relationship between cross-cultural provider-patient interactions and health outcomes.<sup>12</sup> Putsch and Pololi use a broad approach to review both macro-level and micro-level factors contributing to providers' role in health-care disparities.<sup>13</sup>

The second conference was the Inaugural Forum on Reducing Racial and Ethnic Disparities in Health Care in March 2003, sponsored by the National Managed Health Care Congress and AmeriHealth Mercy, a large Medicaid managed care organization. Baquet and Carter-Pokras review the wide range of strategies that emerged from this conference.<sup>14</sup> They present models to reduce healthcare disparities from private, commercial, and Medicaid managed care organizations.

The sixth paper, by Carter-Pokras and colleagues,<sup>15</sup> did not stem from either conference but was included in this issue because of its topical appropriateness. They discuss how use of trained interpreters can overcome problems that providers and patients have in communicating with one another and present interpretation service options.

### **Why Culturally Competent Communication Matters**

Patients bring to the healthcare encounter cultural backgrounds, beliefs, practices, and languages that require culturally competent communication to maximize the quality of care they receive. For instance, patients and providers may have different understandings of the relationships among illnesses, illness symptoms, etiology, expectations about appropriate treatment, and what is expected of them in the process.<sup>16</sup> Also, asking questions of healthcare providers is not an acceptable behavior in some cultures. Patients from these cultures may be less likely to ask even clarifying questions and, subsequently, may not understand their condition or be able to follow their treatment plan, potentially resulting in a lower quality of care or even medical error. Also, many patients utilize traditional remedies and may be reluctant to inform their biomedical providers about them, leading to potentially dangerous interactions between medication prescribed by the 2 types of providers.<sup>17</sup>

When patients and providers speak the same native language, patients are more likely to report positive physical and mental health outcomes.<sup>18</sup> Alternatively, patients' inability to communicate in their native language could lead to delays in care, fewer or missed appointments, nonadherence to therapy, and medical error.<sup>19-21</sup> Providers may further complicate the receipt of quality care if they are unable to comprehend the health complaints of patients with limited English profi-

ciency. Absent adequate translation resources, patients' relatives or hospital staff may be asked to translate, although numerous studies have documented problems with this approach, ranging from mistranslation to patient unwillingness to disclose important but sensitive information in the presence of a family member.<sup>22,23</sup> In this issue, de Bocanegra, Carter-Pokras, and their colleagues discuss in greater detail issues surrounding provision of care to persons with limited English proficiency.

Everyone has a culture, and providers' own cultural backgrounds may affect their communication in the care delivery process if they are unable to recognize or accept differences between themselves and their patients. This may manifest subtly in communication patterns perceived by the patient, or may subconsciously affect clinical decision making. For example, Schulman et al found that physicians had different attitudes toward patient-actors and recommended different treatments for them based on the patients' race and sex.<sup>9</sup> Similarly, van Ryn and Burke reported that physicians' beliefs about the likelihood that patients would comply with advice and participate in rehabilitation varied depending on patients' race.<sup>24</sup> It should not be surprising that support personnel and providers may hold these negative attitudes.

Healthcare institutions also have opportunities for culturally competent communication with their patients and the communities they serve. Some institutions strive to make everyone feel welcome and comfortable seeking care; others send subtle messages that some patients are unwelcome. The former message is more likely to be conveyed when an institution's workforce composition reflects the patient population they serve. Another institution-based cultural-competency issue is signage. Inadequate or English-only signage may send a message—intentionally or not—that non-English speakers are unwelcome, potentially contributing to delays in seeking needed care.

Institutions may make a statement about their cultural competency by not providing sufficient (or any) language translation services. This situation may occur in hospitals located in states that do not reimburse them for translation services, hospitals unfamiliar with the fact that recipients of federal funds are required to provide translation services, or hospitals unaware of their patients' needs.<sup>25</sup> This latter issue is rather salient; about 40% of hospitals do not collect data on patients' primary language, according to the American Hospital Association's annual survey.<sup>26</sup> Even hospitals collecting such data may not make routine use of these data in care delivery settings. For example, many care settings do not have sufficient numbers of professional inter-

preters because the data on members' languages were not consulted to assess need. Thus, translation responsibilities often are left to ad hoc interpreters (ie, staff, patients' relatives), who are more likely to commit translation errors having clinical consequences.<sup>27</sup>

Healthcare institutions and health plans share some challenges with respect to culturally competent communication, such as workforce diversity and language-concordant service provision. Similarly, both healthcare institutions and health plans interact with their communities, providing opportunities for culturally competent communication. For example, some hospitals and health plans actively and effectively engage in community-based outreach or health promotion activities in the surrounding communities, or have and value community advisory boards. Also, the degree of outreach reflected in health plans and hospitals' marketing efforts can send important messages.

Health plans have additional communication-based challenges and opportunities to reduce disparities. One challenge relates to understanding how patients' interpretation of disease and care-seeking behaviors may be conditioned by their cultures. Some ethnic minority members who are reluctant to utilize mainstream medicine may delay seeking care if their health plans do not cover complementary or alternative medical services. Some benefit design and utilization control features may need to account for the diverse needs of members from different cultural backgrounds. For instance, health plans' use of gatekeeping mechanisms to control access to specialty services may inadvertently increase disparities in such care among members from cultures where appealing a decision would not be acceptable.

### Steps to Improving Culturally Competent Communication

How might managed care organizations maximize their ability to provide culturally competent communication and care? Although the evidence base on which to move forward is still being developed, Betancourt, Brach and Fraserirector, and others have identified concrete steps that could be taken, including.<sup>3,8,28-30</sup>

- Making cultural competency a core institutional value. Incorporation of cultural knowledge into policy making, infrastructure, and practice is probably one of the most important actions that can be taken because it would guide the conduct of everyday business.
- Providing ongoing training and evaluation on cultural competency issues. This type of training is relatively new, so its effect on patient outcomes and care quality is relatively unexamined.<sup>31-33</sup> However, as noted earlier, improved communica-

tion in general is associated with improved outcomes and adherence in clinical settings.<sup>1</sup> Aetna is an example of a health plan that has moved in this direction. It now requires its physicians and nurses to complete a cultural competency self-assessment and education program.

- Collecting data on patients' race and ethnicity so quality of care for patients from different racial or ethnic groups can be assessed. Many plans and hospitals have had experience with collecting such data, at least on a limited basis.<sup>7,34</sup> Additionally, plans could consider requiring hospitals and large clinics with which they contract to collect such data and to use these data for quality improvement purposes. In all cases, explaining to patients how these data will be used will be important in moving forward with these efforts.
- Collecting data on patients' primary language. This, too, will help document members' needs and guide service provision. For example, Kaiser's Northern California branch has taken this step by requiring completion of a language field before an appointment can be made.
- Ensuring the provision of professional translation services. This responsibility may need to be shared by health plans and healthcare institutions, depending on their organizational and financial arrangements. Jacobs and colleagues have shown that paying for translator services can be a financially viable solution for health plans once indirect costs (ie, increased utilization of preventive services, potentially reducing long-term costs) are considered.<sup>35</sup>
- Involving consumers and community leaders in the design of programs and services to meet the unique needs of racial and ethnic minority patients.
- Contracting with institutions and providers located in racial and ethnic minority communities and helping patients locate providers who speak their language.
- Increasing staff diversity.

Strategies are in place at the national and state levels to improve providers' cultural competency in healthcare settings. National standards for providing culturally and linguistically appropriate services have been issued by the US Department of Health and Human Services Office of Minority Health.<sup>36</sup> Several state Medicaid programs now reimburse for translation services. Some medical schools are beginning to offer training opportunities specifically on cross-cultural issues, although nursing schools have had national standards requiring cultural content in medical training for almost 3 decades. The papers in this issue illustrate the ongoing work in this area and make it clear that opportunities for improving cultural-competent communication exist in actionable ways.

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