

Part Two

CULTURAL COMPETENCE RESEARCH AGENDAS

I. OVERVIEW

The cultural competence research agenda is divided into three main categories, with detailed discussions for each of the listed subcategories. The categories and format of each discussion is outlined below. These documents should be considered in conjunction with the related documents found in Appendices Two and Four, including a discussion of findings by category, a literature summary matrix, and the abstracts for each article examined.

Categories

Category A: Culturally Sensitive Interventions

- Cultural competence education and training
- Racial, ethnic, and linguistic concordance
- Community health workers
- Culturally competent health promotion
- Family/community inclusion in health care delivery
- Coordination of conventional medicine and traditional practices/healers

Category B: Language Assistance

- Language barriers
- Bilingual services and oral interpretation
- Translated written materials

Category C: Organizational Supports for Cultural Competence

- Management, policy and implementation strategies to institutionalize cultural competence activities
- Community involvement in cultural competence program planning, design, implementation, training, and research
- Design and use of surveys and profile instruments to plan for services, and measure satisfaction and quality
- Cultural competence self assessments and ethnic data collection/community profiles
- Culturally appropriate ethics, conflict, and grievance resolution processes
- Public information about CLAS standards performance
- Implementation of the all CLAS standards as a comprehensive organizational strategy

Format

Each category has its own research agenda discussion, with subcategories broken out separately for Categories A and C. The discussions include the following elements:

- *Definition of the Category*: Provides descriptive information on the cultural competence intervention.
- *Synthesis of Findings from Literature Review*: A brief summary of the key findings from the literature review conducted for this project. More detailed discussions of findings can be found in Appendix Two.
- *Key Research Questions*: Includes both research that attempts to further define/understand the intervention itself, and research that looks at specific outcomes.
- *Methodological and/or Policy Considerations Influencing Future Research*: Select considerations for researchers and/or policymakers interested in this area.

II. CATEGORY A: CULTURALLY SENSITIVE INTERVENTIONS

Research Agenda on Cultural Competence Education and Training

Definition

Cultural competence education and training broadly describes a vast array of educational activities aimed at enhancing the capacity of the individuals and the service delivery system to meet the needs of different racial and ethnic populations (hereinafter referred to as cultural competence training). The literature suggests that cultural competence training can include educational activities aimed at increasing sensitivity and awareness; the provision of multicultural health and demographic information on service area populations; skills building in bicultural and bilingual interviewing and patient assessment; enhancing the use of race or ethnic-specific epidemiological data in diagnosis and treatment; and increasing cultural knowledge and understanding. Training can be designed for individuals in clinical, support, administrative, and governance positions. It is believed that the knowledge and skills gained through training will enable providers and institutions to work more effectively in cross-cultural situations by developing new approaches to communication, patient care, and services planning that are based on cultural and linguistic needs.

Synthesis of Findings from Literature Review

The literature findings on education and training can be separated into three groupings: descriptive studies, the impact of education and training on participants, and the impact of education and training on patients.

Descriptive Studies

The majority of the literature encompasses descriptive studies of cultural competency training, delivery approaches and techniques; arguments for using training as a means to eliminate disparities; and surveys of the prevalence of training in different educational settings. The literature focuses primarily on cultural competence training in the context of formal educational programs or post-graduate residency training for health professions. Additional work is needed on the prevalence and format of training in workplace-based training or continuing education for practicing professionals. The content of training described in these studies varies widely.

Findings suggest that additional research is needed to determine whether the standardization of cultural competence education is appropriate and effective, how established goals and objectives can be empirically measured, and the best approaches for attaining health care delivery and health outcomes.

Impact of Education and Training on Participants

Most of the remaining literature attempts to answer questions related to the impact of training on training participants. In an attempt to quantify the impact of training on participants, studies examined levels of cultural knowledge, attitudes, awareness, satisfaction and communication skills overall. Studies that empirically measured the impact of training found that self-assessments indicated significant increases in levels of cultural knowledge, attitudes and awareness in both single and comparative groups. However, some studies using non-subjective measures found that knowledge improved in a few areas but not others. Other studies documented modest improvements in some attitudes, but few improvements in communication skills. Studies that examined the impact of training on sensitivity generated inconclusive and often contradictory results.

Several comparative studies attempted to determine the impact and effectiveness of variations in training presentation and content. These studies reported different levels of improvement in knowledge, awareness, and cultural sensitivity, frequently relying on self-report assessments rather than objective behavioral assessments. However, other studies found no empirically measured differences.

Impact of Education and Training on Patients

Very few studies examined the impact of training on patient behavior change or on health care delivery and health outcomes. There is a need to define which are the most desirable outcomes related to the patient-provider relationship, and which are the most reliable indicators of positive improvements that could result from training. One interesting study, which may provide a model for future research, attempted to measure the impact of training from the perspective of the patient using both subjective and objective measurements. It found that clients assigned to experienced counselors who received cultural sensitivity training rated their counselor higher on credibility and relationship measures, returned for more follow-up sessions, and expressed greater satisfaction with counseling than did clients assigned to experienced counselors who had not received the additional training. Research activities currently underway by others will attempt to assess the impact of cultural competence training on measures of competency, patient trust and satisfaction, adherence to treatment, and subsequent health care delivery and health outcomes.

Key Research Questions

The literature on cultural competency education and training made the assumption that positive impacts on training participants will result in behavioral changes that will facilitate the delivery of culturally competent care. It is also assumed that these changes will eventually translate into improvements in health care delivery and health outcomes, including satisfaction. Clearly there is a need to examine and validate each of these assumptions, including an examination of the types of education that have the most effective impact on subsequent outcomes.

Trainees and Motivation

- Should all management, clinical, and support staff, as well as those being educated to assume those positions, receive cultural competency training?
- Is the likelihood of better health care delivery and patient health outcomes (including improved satisfaction) sufficient to motivate attendance, or must there be additional incentives (financial or otherwise)?
- How big does the perceived payoff (including incentives) have to be for trainees to be willing to expend time and energy in cultural competence training?
- Is it sufficiently motivating to learn more effective communication skills, or must clinicians be persuaded by scientific/empirical evidence that demonstrates better health care delivery and patient health outcomes from training?
- Do motivations differ by ethnicity of the trainee, or different practice settings (e.g., solo practice, patient populations of different socio-economic status, public versus private, clinic versus non-clinic)?
- Is there a threshold of the number of patients of a different ethnicity or multiple ethnicities that contributes to the motivation?

Content of Training

- Which competencies and basic skills produce behavioral changes by trainees and improvement in health care delivery and health outcomes?
- How should curricula be tailored to address the needs of individual disciplines and/or educational settings?
- Which aspects of training can be generic in content, and which aspects should focus on specific cultures or ethnic groups?
- Can education on cultural issues translate into changes in behavior and service delivery in the absence of skills training?
- How can the danger of reinforcing negative perceptions and attitudes be minimized?
- How do curricula designers best gather and incorporate information on how clients want to be treated in health care encounters (which may vary by ethnicity)?
- How can organizations best monitor and revise their curricula to respond to changes in the demographics of an institution's service population?

Form of Training

- Which educational delivery techniques (e.g., mentored clinical contacts, videotaped consultations, student log-books, community medicine projects, affective methods, and didactic methods) are most effective at changing trainee behavior?
- Does training have to be tailored to different groups of trainees (e.g., management, clinical, and support staff) to achieve better results than undifferentiated training?
- What is the impact of format, content, and length of training? Is there any measurable, long-term effect of one-time training interventions?

Achieving Behavioral Changes Among Trainees

- Which methods are most reliable for assessing the impact of training on knowledge, attitudes, behaviors, and skills?
- Do the effects of training vary among different types of trainees (e.g., students, practicing clinicians, non-clinical staff, various disciplines)?
- What degree of knowledge or awareness translates into action? Is there a dose-response relationship for certain training interventions, and what is the minimum intervention that will result in acceptable outcomes?
- How can behavioral changes be sustained?
- Are there outcome differences associated with individuals who have a prior interest in cultural issues, or who have very diverse client profiles?
- Can variations in provider behavior be attributed to a certain level of knowledge, awareness or sensitivity?

Impact Research

What is the impact of the training on health care delivery and health outcomes, and which outcomes are the most appropriate to measure? Possibilities include:

- Adherence to treatment recommendations
- Keeping recommended follow-up visits
- Appropriate utilization of primary and emergency services
- Less restrictive placements
- Patient satisfaction
- Diagnostic success
- Morbidity measures such as exercise tolerance for cardiac patients, missed days of school/work for asthmatics, hemoglobin A1C for diabetics, etc.

Methodological and/or Policy Considerations Influencing Future Research

Variations in studies highlight a fundamental problem with the myriad definitions of training: since there is no universal standard for training, nor a standard definition of cultural competence, there can be no comparability among existing studies of the “cultural competence” of subjects participating in different training programs. This further supports the need for a more thorough examination of the types of competencies needed in various disciplines and educational settings, and the setting of standards of training for different target audiences.

Methodological problems associated with assessing the impact of cultural competence training include relying on subjective self-assessment of cultural competence, knowledge and awareness. Some use independently developed assessment tools, others use tools designed for use with training curricula. Many rely on knowledge-based tests rather than observations of behavior and subsequent change. This may present a false sense of security on the part of individuals who are able to absorb facts and theorize easily, but have difficulty putting them into practice, while falsely validating specific training modules. Subjective self-assessments should be augmented with objective assessments of cultural knowledge, and client assessments (satisfaction, grievances, etc.) tied to individual clinicians.

Future research should consider examining the impact of training on providers and their clients. Many of the studies examining training involved students, not providers, and therefore changes in behavior or service delivery could not be assessed. Training for individuals in support, administrative and governance positions should also be evaluated for impact on day-to-day staff-client interactions, as well as on sensitivity and responsiveness to cultural/linguistic issues in health services planning.

As with other types of training geared towards trainee behavior change, critical questions arise related to the difficulty of establishing firm linkages between cultural competence training and subsequent trainee behavior and/or impacts on health care delivery and health outcomes. These may include the following:

- Can we isolate the impact of training from inherent skill, personality, and other intangibles?
- How do we measure and evaluate the impact of training on health care delivery and health outcomes?
- Is it reasonable to expect evidence of training's ability to improve health outcomes, or should training only be held accountable for achieving intermediary effects, such as improving communication?

Stakeholders should be aware that most training topics or modules regularly undertaken by health care professionals have not been definitively linked with subsequent outcome improvements, and this linkage (or lack thereof) is not taken as an indicator of value. Many RAC members felt that cultural competence training should not be held to a higher standard.

Research Agenda on Racial, Ethnic, and Linguistic Concordance

Definition

Racial, ethnic, and linguistic concordance refers to the process of matching any or all such characteristics between patients/consumers and clinicians. The underlying assumption behind this process is that commonality with respect to these characteristics will lead to a higher degree of rapport between participants in a clinical encounter by eliminating differences in cultural and linguistic backgrounds that lead to misunderstandings, leading to a positive impact on outcomes.

Some literature suggests that concordance may be relevant beyond the clinical encounter to encompass race/ethnic/language-specific clinic sites or programs. It is theorized that successful delivery of health services to different racial and ethnic populations requires an understanding of the cultural milieu of each distinct community, as well as the trust of communities and individual patients. This understanding and trust can be obtained by instituting service and support staffing patterns that mirror the targeted service population. Incorporating a team that reflects the community dynamics can instill this assurance and assist in the development of culturally appropriate and acceptable care essential to a successful program.

Synthesis of Findings from Literature Review

The literature suggests that some patients from multicultural groups prefer to seek care from providers of their own race, ethnicity, or language group, and that such concordances appeared to have a positive impact on appropriate service utilization, treatment participation, and receipt of some services, although impact on satisfaction was inconclusive. The literature on the effects of positive outcomes in utilization was not shown to translate into improvements in health outcomes. Research was conducted with Asian, Hispanic, and black concordant encounters, but findings should be considered specific to the groups studied, and not generalizable across ethnic groups. Research currently pending publication on the relationship between patient-centeredness and race-concordant visits suggests that patient and physician age and gender are significant confounders in the relationship between race-concordance and communication styles.

The literature particularly appears to support the benefits of language-concordant encounters, showing that language concordance between patients and providers eliminates many of the problems associated with language barriers. However, further research should examine the differential impact of concordant encounters with those using interpreters.

Key Research Questions

Concordance and the Clinical Encounter

- What specifically is important about concordance in medical encounters: is it race, ethnicity, gender, age, socioeconomic status, culture, language, and/or communication style(s)?
- What can we learn from concordant encounters about the factors that could be emulated in non-concordant encounters? Which factors are not definable or replicable? Are there factors that are common across racial/ethnic/language groups, or does each cultural group respond to their own unique factors?
- Can greater satisfaction, or other health care delivery and health outcomes be affected by clinician non-race/ethnic factors, such as a patient-centered provider approach, age or gender? How does this combine with concordance factors such as race, ethnicity, gender, age, SES, culture, language, patient-centeredness, and/or communication styles?

- Do matches on exact cultures (as opposed to, for example, language groups or regions) yield better health care delivery and health outcomes? How precise do matches have to be in order to have an impact on outcomes? At what level is concordance most productive? For example, is there greater positive impact on intermediate outcomes for concordance between broad groupings, using categories such as Hispanic or Latino, or for more specific concordance (e.g., Puerto Rican providers with Puerto Rican patients)? What portion of the change in the outcome can be attributed to differences in gender, age or level of acculturation within these concordant categories?
- Do findings related to health care delivery and health outcomes in concordant encounters vary by different racial, ethnic or linguistic groups? For example, would recently-arrived Bosnian refugees in concordant encounters show more positive outcomes than third generation, English-speaking Latinos? Is there a variable impact related to the effects of: length of time in this country, acculturation, educational level, religious and gender matching, experience of war/trauma/torture? Which variables are most relevant when there are multiple variables, and should they be tracked separately?

Patient-related Health Care Delivery and Health Outcomes

- Does concordance affect patient/consumer: comprehension, satisfaction, appropriate utilization of services, and adherence to treatment, perceived health status and/or quality of life measures? Do positive outcomes in any of these areas correlate to medical condition/health status improvements?
- Does a lack of choice of concordant providers have an impact on overall health service utilization or satisfaction with a health care system or plan?
- Does a lack of concordant support staff affect perceptions of a system or plan, service utilization, or satisfaction?
- Does the impact of concordance change over time? Is the need for concordance greater at the beginning of clinical/organizational relationships as a means to establish trust?

Clinician-related Outcomes

- Does concordance have an effect on clinician behavior/perceptions? Measures could include time spent with patients/consumers, number of treatment options discussed, level of interaction, number of questions the patient is allowed to ask, negotiation of treatment options, clinician perceptions of effectiveness of his/her efforts. How does the health care delivery and health outcomes of concordant encounters compare with those for clinicians who have received cultural competence training? What factors and behaviors can be found in both types of encounters and which are not replicable?
- What is the effectiveness of cross-cultural training to make generally concordant pairs more effective? (e.g., programs to expose African-American providers to Caribbean health beliefs and practices? What effect might cross-cultural training have on the attitudes and communication practices of the clinicians who participate?)

The Impact of Concordance on Organizations

- What are the broader implications of concordance outside of the medical encounter, particularly the systemic implications? Is it simply a “wallpaper” effect— that the visual evidence of diversity is reassuring to patients.
- Does concordance achieved through a diverse staff improve the service design and delivery efforts targeting multicultural communities?
- Does the overall level of staff awareness and sensitivity to cultural issues improve when there is diversity throughout the organization? What mechanisms exist in the organization to facilitate communication and learning among staff and across the organization?
- Does tension arise among staff from efforts to diversify staffing to achieve concordance? What are the repercussions of such efforts, and what impact does this have on the delivery of culturally competent services?

Methodological and/or Policy Considerations Influencing Future Research

RAC members identified difficulties recruiting ethnic minority clinicians into this kind of research. The main reasons for recruitment difficulties appear to be related to lack of time, lack of financial incentives, and lack of perceived benefit to the providers themselves. However, the recent positive findings related to racial concordance have led some providers to become more willing to participate.

Studies that collect data using direct observation, such as through audiotape and videotape, and other qualitative methods (e.g., focus groups, in-depth interviews, transcripts of actual encounters) might shed more light on the relationship of clinician and patient perceptions of one another to race and ethnic concordance.

RAC members disagreed about the potential applications of provider-patient concordance. The majority of participants expressed uncertainty about the implications of pursuing concordance as a policy or organizational goal. Such a goal is probably unachievable on a national scale for the foreseeable future, given the current demographics of health professionals in practice and in training. However, current research suggests that patients perceive and experience positive benefits from concordant encounters, suggesting an adequate rationale for providers to pursue this strategy as an organizational goal when reasonably achievable.

Aside from outcomes considerations, further research on the dynamics of concordant encounters and ethnic-specific clinics and programs could be very helpful in improving non-concordant encounters through program design and staff training. Continued research can assist with better understanding the factors about discordance that are dissatisfying to patients. It can inform practitioners in discordant relationships what they should be wary of or address differently, thus increasing the possibility that they can establish patient trust and comfort early in the clinical relationship.

Research Agenda on Community Health Workers

Definition

Community health workers (CHWs) are typically members of a particular community whose task it is to assist in improving the health of that community in cooperation with the health care system or public health agencies. The literature suggests that CHWs can work as agents of change by providing a variety of services, including outreach to underserved and hard-to-reach populations; health promotion/disease prevention educational instruction; patient tracking, needs assessment and the provision of follow-up services; patient advocacy and assistance; and, in some instances, delivering limited health care services.

Although many of these services are capable of being delivered through a direct systems-based approach, CHWs are often trained to integrate a more culturally and linguistically sensitive approach in a community setting. In addition to being part of the existing community and social network, CHWs ideally possess certain skills and capacities that are essential to gaining the trust and acceptance of individuals. These may include cultural communication and mediation skills, an understanding of the community's health belief systems and knowledge of a community's strengths and capacities, and the ability to use effective approaches for reaching targeted individuals. Through an integrated approach, CHWs can theoretically facilitate a better understanding of the changes that are sought without threatening the interests or cultural values of the community.

In addition to influencing health-related behavioral change and health outcomes in targeted communities, CHWs can also assist systems and service providers by soliciting information on community barriers, patterns of social interaction and decision making, past efforts aimed at changing health behaviors, and associated successes and failures. This information can enable providers and institutions to adopt methods more acceptable to the targeted community.

Synthesis of Findings from Literature Review

Descriptive

There is a sufficient literature base that describes the use of community health workers/lay health advisors, the content and structure of CHW-assisted programs, and the methodologies by which CHWs were integrated into specific programs as part of a corrective strategy to supplement or modify existing initiatives. The literature highlights variations in training and preparation, roles and responsibilities, and controversies associated with using CHWs.

This literature can provide the foundation for further meta-analysis related to the utility of CHWs, core competencies, associated data collection, institutional and structural barriers to using CHWs, and potential models for duplication. This base can be used to identify those cultural components that make the work of CHWs more effective in meeting community-based needs.

Impact Research

Literature that empirically measures the impact of CHWs is limited, and surveys conducted by other institutions validate this finding for both published and non-published sources. Studies that attempted to quantify the impact of CHWs on various health care delivery and health outcomes looked at the effect of CHWs on patient satisfaction, knowledge, service utilization, and health status. No studies were identified that examined the cost effectiveness or cost benefits of using CHWs.

Findings suggest:

- CHWs were effective in increasing health-related knowledge and self-care practices through educational instruction. They were also credited with higher rates of health promotion course completion.
- CHWs facilitated behavioral change in the target population by providing encouragement, support and serving as role models. Increases in screening rates were attributed directly to their use in several studies.
- CHWs were effective in decreasing high-risk behaviors in the target population.
- Enhanced case management tracking and monitoring of patients by CHWs resulted in better follow-up with medical care.
- The use of CHWs was highly valued by administrators, program staff and clients.
- Virtually no studies linked CHWs directly to health outcomes, and those that did often did not compare the use of CHWs to no intervention.

Key Research Questions

- What are the specific roles and responsibilities of CHWs?
- How are interventions delivered by CHWs?
- What are effective strategies for partnerships between CHWs and health care organizations?
- Are credentialed CHWs more effective than non-credentialed CHWs?
- What are the indicators or standards for successful CHW programs?
- What is the most effective use of CHWs?
- What proportion of the targeted population is successfully reached by CHWs?
- Do variations exist in levels of successful outreach when using CHWs as an intervention versus other methods of outreach (i.e. case management)?
- What institutional barriers prevent the use of CHWs? How have these barriers been overcome?
- Is the use of CHWs a cost effective alternative to other comparable interventions when you include stakeholders' valuations? Is it appropriate to use cost as a measure of success?
- How can the effectiveness of CHWs be improved?
- Which components of the CHW's role impact behavioral change?
- Of these behavioral changes, which can be linked to improvements in health care delivery and health outcomes?
- Is it realistic to link CHWs to health outcomes?

Methodological and/or Policy Considerations Influencing Future Research

The RAC highlighted methodological concerns that could affect future research efforts. These include:

- The difficulty of standardizing relationships between CHWs and their clients. The literature describes CHWs as having a very dedicated advocacy role and an individualized approach that differs from worker to worker. The relationships that CHWs form with individuals in the target population, and even client to client, often cannot be individually standardized, but researchers and program directors can outline the content of patient instruction/interaction, as well as processes to develop relationships and trust that can be standardized and measured.
- Data collection on CHWs and their clients is not standardized and often more qualitative, thereby hampering comparative analyses.
- Length of study, compounded by a lack of personnel and financial resources, will be barriers to conducting health care delivery and health outcomes research or any ongoing monitoring of behavioral changes.
- Difficulties reaching populations, high attrition and the mobility of populations compound difficulties in long-term studies.
- Ambiguous definitions of “community.” Systems often mistakenly assume that a community is an aggregation of individuals of a similar race, ethnicity, language or geographic locale, and do not take into consideration social and organizational factors that links individuals to a specific community.

Research Agenda on Culturally Competent Health Promotion

Definition

Health promotion refers to the process by which individuals, communities and populations are given the tools necessary to improve health care delivery and health outcomes. *Culturally competent health promotion* (CCHP) implies the incorporation of culturally sensitive concepts and practices into health promotion activities. Developing CCHP policies and interventions entails the integration of a multilevel community organization and development approach. Activities associated with this approach include community input into the design, implementation and evaluation of programs and associated activities; a comprehensive understanding of the health issues and needs of the target population; and the provision of health information and education. When conducted with a high degree of cultural and linguistic specificity, it is hypothesized that these interventions can be more effective in improving outcomes.

Synthesis of Findings from Literature Review

The literature suggests that culturally competent health promotion consists of a variety of approaches aimed at improving health care delivery and health outcomes by promoting healthy behaviors, early detection and treatment of disease, and care of chronic disease. The programs examined used individual culturally and linguistically sensitive interventions, or several interventions in combination, to improve outcomes. These include community input in the planning process, multicultural providers, racial/ethnic concordance, traditional healers, lay health workers, community health workers, public health campaigns, translated materials or culturally sensitive material, interpreters, multilingual informational videotapes and cultural competence training. Due to the number of interventions that can be used to define CCHP programs, the amount of descriptive literature highlighting the design, methods and processes of such programs is tremendous.

Although limited, studies that empirically measured the impact of CCHP programs on outcomes examined satisfaction, service utilization (e.g., impact on screening rates), increases in health knowledge, changes in health behavior and practices, and prevention. Findings suggest that some of the individual interventions associated with CCHP programs were found to have added value while others had inconsistent results. Community health workers were found to have a successful impact on recruitment into screening and health education programs and assisted in the facilitation of program completion. (For more details, see the Research Agenda on Community Health Workers.) Several studies attempted to measure both knowledge and behavioral change as a result of program participation. While some studies indicated increases in both measures, others found that increases in knowledge could not be linked to behavioral changes. Another study revealed that the impact of one CCHP program on different racial and ethnic study populations revealed different results for different ethnic groups.

In those studies that reported positive results on intermediary outcomes, no scientific links could be made to improvements in health outcomes. However, it was theorized by some authors that subsequent changes in health status could be attributed to the positive impact of these interventions.

The literature also revealed gaps or weaknesses in methodological design when examining the impact of CCHP programs and associated interventions on health outcomes. Very few studies were identified that specifically document improvements in health outcomes as a result of integrating culturally sensitive interventions into the delivery approach. Although comparison studies were conducted between CCHP and other case management approaches, no highly controlled designs examining the impact of culturally sensitive program intervention versus a standard health promotion program were identified, thereby weakening the findings of those studies that did report positive improvements in health outcomes.

Key Research Questions

- What is the impact of culturally competent health promotion programs versus standard health promotion programs on knowledge, behavioral change, and health outcomes?
- What are some of the indirect benefits of CCHP (e.g., greater family involvement and support in the care of patients)?
- Is there a significant improvement in health care delivery and health outcomes when the intervention is highly tailored to subgroups and subcultures as opposed to generalized culturally competent health promotion programs?
- What methods are effective for incorporating community input into the design, implementation, and evaluation of CCHP activities?
- Which elements of the culturally sensitive methods utilized by CCHP programs improve access, quality and utilization of services?

Methodological and/or Policy Considerations Influencing Future Research

The Research Advisory Committee (RAC) expressed concern about future research efforts directed at assessing the impact of culturally competent health promotion interventions. Many felt that breaking up a multi-component culturally competent health promotion program into discreet elements for the purposes of evaluation (e.g., the impact of interpretation, family inclusion, or lay health workers) would result in a dilutional effect of the overall intervention, and determining the impact of these elements may not be possible. The RAC also suggested that research assessing the impact of CCHP efforts may need to be conducted on specifically targeted cultural groups and subcultures, and success may need to be defined as it relates to the targeted populations.

Concern was also expressed regarding the availability of theoretical models, and lack of instruments and methodologies to measure and validate CCHP elements. Suggestions were made to include both quantitative and qualitative approaches in the assessment of culturally sensitive interventions.

Future efforts should focus on appropriately controlled experiments measuring the impact between standard programs and culturally competent programs in addition to attempting to measure the impact of the intervention compared to no intervention. However, detection of the marginal benefits of CCHP over health promotion interventions that were not specifically culturally competent would prove difficult without extremely large sample sizes due to the modest size of the expected effect.

Research Agenda on Family/Community Inclusion in Health Care Delivery

Definition

Family/community inclusion refers to the participation of family members or community-based networks in the development, implementation and decision-making processes of health care delivery. The underlying assumption supporting inclusion is that, through greater participation, family members and community-based networks can act as agents of change to facilitate improved social, behavioral and health outcomes more effectively than an exclusively health care system-based approach. Through the process of inclusion, essential cultural issues affecting service delivery and utilization can be identified by families and/or communities, and integrated into more responsive health care.

Synthesis of Findings from Literature Review

Research on the impact of family/community inclusion examined two distinct activities: inclusion of family/community in clinical encounters, and community involvement in the planning, design and implementation of programs and research. Studies described a variety of mechanisms for involving community members in the development of different organizational supports for culturally competent activities such as clinical training, survey design, health promotion program design, and developing community profiles. The authors of these studies theorize that family/community inclusion:

- Increased screening rates.
- Assisted medical providers in overcoming challenges in caring for elder patients.
- Positively influenced the participation of individuals in training programs.
- Assured the cultural acceptability of research tools leading to higher response rates and increased access to information about the community.

However, it should be noted that none of these studies used experimental research to measure the impact of inclusion on health care delivery and health outcomes or community-based participation. Therefore, further studies are needed to validate these findings.

Key Research Questions

The RAC suggested a need to further define and isolate specific aspects of both family inclusion and community participation that may improve care, and to identify models that warrant replication. Before inclusion can be justified as an intervention, efforts need to be made to understand the mechanisms of family and community involvement, how these mechanisms subsequently impact health encounters and practices, and whether the effects of inclusion can be isolated from other confounding variables in order to be linked to measurable outcomes.

Characteristics of Family Inclusion in the Health Care Encounter

- What methods can be used to determine whether inclusion is appropriate in a particular medical encounter, to what extent, and in what capacity should family members be involved?
- What positive and negative elements of provider-patient-family interaction can be identified?

- What is the best way to teach providers to facilitate the inclusion of all parties without over-extending the encounter period?
- What impact does family inclusion have on the amount of clinically/psycho-socially relevant information exchanged between the patient/family and the clinician, retention of information from a health encounter, satisfaction with the encounter/clinician, adherence to recommended treatment, and outcomes of conditions that could benefit from social support (e.g., chronic disease management, consistent prenatal care, weight loss)? Other possible outcomes include improved patient satisfaction, improved family satisfaction, and increased likelihood that patient desires regarding level and type of intervention are adhered to.

Community Involvement in Health Care Planning and Delivery

(For further discussion of this issue, see Category C: Research Agenda on Organizational Supports)

Questions related to community involvement are aimed at isolating those characteristics of community that may have an impact on health care delivery and health outcomes, and community involvement as an intervention. Desirable outcomes might include more community support for individuals or families during illness, routine involvement of the community program design and delivery, greater community acceptability and utilization of health programs, and greater satisfaction with health programs.

- Which characteristics of community support or facilitate positive social and behavioral outcomes in health programs? Who are the appropriate representatives to involve? What level of involvement should be sought, at what points in the process, and over what period of time?
- Do specific attributes or mechanisms of community involvement have a measurable effect on desired health care delivery and health outcomes?
- How can the impact of community involvement on health care delivery and health outcomes be measured? Are different measures appropriate for different communities?
- What skills are needed by health planners and providers to successfully solicit community input and integrate that input into health planning and delivery?

Methodological and/or Policy Considerations Influencing Future Research

It may be difficult to manage and account for some of the complex variables that arise when looking at the impact of family and community on health care delivery and health outcomes. For example, conflict between patients and family, multiple community stakeholders with differing perspectives or agendas, and other psychosocial dynamics may confound results. The definitions of a successful outcome may also vary by stakeholder group

Research involving community collaboration or participation often requires more time than other types of health services research because time must be spent in relationship building and negotiating the needs/opinions of health care planners and community members. Grants should take this into account and funding agencies should provide more protected time and overall project time for this type of research.

Research Agenda on Coordination of Conventional Medicine and Traditional Practices/Healers

Definition

Coordination of conventional medicine and traditional practices/healers refers to the blending of Western medicine with that of other cultures. In many ethnic communities, health status, disease causality and health care treatment may be defined or explained through traditional or folk models. These models differ from Western biomedical explanations in that illness could be caused by injuries, environmental factors, or interpersonal conflicts; attributed to witchcraft, sorcery, spirits; or result from violating cultural, religious, spiritual or traditional norms. Responses can differ from that of conventional medicine, resulting in the use of traditional practices/remedies such as herbal remedies, acupuncture, massage, and prayer rituals; and /or consultation with traditional healers or practitioners. For some, the use of traditional practices/healers may be the first and only approach to dealing with health-related concerns, while others may feel that coordination of both traditional and conventional approaches is beneficial. Understanding these alternative models may help to uncover potential barriers to service delivery while providing the opportunity to integrate specific components into conventional practice.

Synthesis of Findings from Literature Review

An extensive amount of literature was identified that describes alternative diagnostic/prevention methods, traditional healing practices utilized by individuals, and the use of traditional healers. These descriptive articles argue persuasively that culturally competent care should attempt to coordinate components of alternative systems and practices with conventional approaches to care.

The majority of literature examining the impact of traditional practices/healers is process related; very little research was identified that measured the impact of the interventions on health care delivery and health outcomes. Several studies examined issues such as motivation for seeking care, frequency of use, whether traditional practices were used in conjunction with conventional services, and level of awareness and knowledge regarding alternative methods. Findings from these studies suggest:

- Traditional healers are consulted for common medical conditions.
- Using alternative methods in conjunction with conventional methods can be an effective approach to avoid conflict between therapies, improve communication between patients and providers, and to help increase adherence to recommended treatments.
- Patients are reluctant to inform clinicians and other members of their community about the use of traditional practices/healers for fear of judgment and stigmatization.

A few studies describing methods by which traditional healers were integrated into conventional systems of care were identified. These studies detailed how traditional healers were used as consultants in cases involving traditional beliefs and subsequent increases in service utilization were attributed to their use.

Key Research Questions

- How does failure to coordinate/integrate adversely affect patients (e.g., dangerous interaction between conventional and traditional treatments, poor communication, failure to adhere to treatment and/or return for follow-up visits)?

- What motivates patients to attempt to integrate traditional practices with conventional medicine? At what point do they make these decisions, and how do they go about coordinating care? How do patients decide whether to share their participation in traditional treatment with conventional clinicians, and how can this sharing be encouraged?
- How can traditional healers/practices be coordinated with conventional medicine? What models might be appropriate for implementation (e.g., programs for certain conditions vs. others; programs that coordinate both types of practitioners at one site vs. services coordinated remotely)?
- Do patients show improvements in certain outcomes (satisfaction, adherence to treatment return for follow-up visits) when participating in coordinated care vs. conventional care alone?
- Which approaches to coordinated care have the greatest impact?
- What types of conflicts arise when attempting to coordinate traditional and conventional treatments or to be supportive of dual but separate treatment-seeking by patients? What are the most effective resolution processes to mediate conflicts that arise as a result of the use of traditional and conventional practices?
- What are the concerns of Western clinicians who are reluctant to coordinate or acknowledge the use of traditional practices/healers? What preparation is needed by clinicians and health care organizations to make coordination successful?
- What information or training helps clinicians and other staff effectively coordinate with traditional healers/practices?

Methodological and/or Policy Considerations Influencing Future Research

Methodological challenges related to this research include difficulties in:

- Mounting coordinated/integrated programs to study, due to the challenge of obtaining funding for both research and the demonstration project.
- Structuring good comparisons (i.e., when coordination does not take place, it is still necessary to quantify traditional use and problems with lack of coordination).
- Identifying what elements of coordinated programs are responsible for positive results.
- Being able to generalize beyond one particular model approach or community that is being studied.

Researchers should be alert to the need to actively involve ethnic community representatives and/or traditional healers in study design and execution. RAC members also expressed concern that this research focus on the dynamics and outcomes of coordination, and not on testing the “efficacy” of traditional treatments or healers. (The NIH National Center on Complementary and Alternative Medicine is looking at efficacy questions related to many traditional practices.)

From the practice and policy perspective, what are the implications of supporting/encouraging the use or integration of traditional practices/healers in the absence of funding or reimbursement? Given that some insurers are offering partial coverage of “alternative” therapies such as acupuncture and massage therapy, how do providers fairly decide which treatments to cover or offer, lacking studies that conclusively demonstrate the efficacy of traditional treatments?

III. CATEGORY B: LANGUAGE ASSISTANCE

Research Agenda on Language Barriers, Bilingual Services, Oral Interpretation, and Translated Written Materials

Definition

Language assistance refers to interventions, such as bilingual services, oral interpretation, and translated written materials, to overcome language barriers and improve the quality of health care. While guidance from the U.S. Department of Health and Human Services requires health care providers who receive Federal funds to ensure that language barriers are bridged between limited-English-proficient (LEP) patients and providers, how and whether this is achieved varies considerably. The lack of a widely accepted standard definition for qualified interpreters or a quality standard for translated written materials has implications for studying the impact of these interventions on health care delivery and health outcomes. (For details about the linguistic interventions described here, please consult the text, commentary, and discussion on CLAS standards 4-7, in the CLAS Standards Report (U.S. Department of Health and Human Services Office of the Secretary, 2000).)

Synthesis of Findings from Literature Review

Findings from the literature search can be separated into two themes; studies that analyze or describe the impact of language barriers on outcomes and those that examine the impact of language assistance services on health care delivery and health outcomes. The literature defines language assistance services as the use of bilingual staff communicating directly with patients, the provision of interpretation services through professionally trained (or untrained) interpreters, bilingual clinical/support staff, or family members; and the dissemination of translated written materials. Outcomes examined in the literature include patient satisfaction and perceptions of care, patient comprehension, utilization of health services, referrals, adherence, quality of interpretation and patient-provider communication.

Impact of Language Barriers on Health Care Delivery and Health Outcomes

Studies that examined the impact of language barriers on health and health care have documented the need and importance of providing language assistance services. Language barriers were consistently reported to decrease satisfaction among LEP patients. Research also shows that patients who face language barriers make fewer visits to clinicians and receive fewer preventive services. Studies reported that LEP patients spent less time in the emergency department encounter, were less likely to use or return to clinics, received less testing and prescriptions than English speaking patients, scored lower on health knowledge and had longer hospital stays.

LEP participants also noted that testing and medication side-effects were not explained, and studies found that patient understanding of diagnosis and treatment was also affected. Language barriers also contribute to inaccurate communication, misdiagnosis, and inappropriate treatment. Limited English speakers have also been found to receive fewer preventive services, report worse health status, and are less likely to have a regular source of care. These findings support the assumption that language differences create significant barriers to care, and that valuable medical information is not being communicated to or from the provider in the absence of language assistance services, thus compromising access to health care and the quality of the clinical encounter.

Impact of the Provision of Language Assistance on Health Care

The majority of studies measuring the impact of language assistance services assessed impact of interpreter services on outcomes such as:

- Patient and provider satisfaction with different forms of language assistance services, patient satisfaction with specific health service sites or departments, and satisfaction with level of communication during the clinical encounter
- Patient's understanding of diagnosis and treatment
- Utilization of services (emergency, preventive and primary care)
- Adherence with follow-up appointments
- Length of stay
- Duration of health care encounter
- Number of tests

Studies examining the impact of language assistance services on the outcomes listed above report increases in patient satisfaction and a decrease in the number of problems reported in the patient-provider encounter. Findings from these studies also suggest that more highly qualified interpreters (those with training and/or qualifications) had greater impacts, although variations among study designs and intervention characteristics prevent any further generalization of findings.

Several studies suggested that improvements in the delivery of care and utilization of services are linked with the use of interpreter services. They reported increases in the amount of time spent with patients, reduction in diagnostic testing disparities among English-speaking patients versus LEP patients, higher clinic return rates, and increases in primary care services utilization. Variations in the number of tests ordered may be attributable to several factors including the use of excessive testing in the absence of quality verbal patient assessment and medical history taking. Studies also reported graded increases in health knowledge with the provision of different types of language assistance services. One study looking at the financial impact of interpreter services reported that non-English speakers incurred higher mean costs for diagnostic testing when language barriers went unaddressed. With the assistance of professional interpreters, no increase in testing costs was noted above a control group of patients who were English-speaking.

The Interpretation Process and Translation

Additional studies examined the quality and accuracy of various forms of interpretation services and differences in mechanisms of delivery. Specifically, these studies examined the use of family members as interpreters to determine the quality of interpretation, distortion in interpreter-related messages during clinical evaluations, number of patient-provider utterances and comments, and frequency of errors and satisfaction. This literature documented some problems in interpreter encounters, especially when untrained interpreters are used.

One study suggested a reduction in the level of patient-provider communication when using interpreter services, as comments rendered by patients through an interpreter were often ignored by providers. Some studies reported reduced satisfaction, embarrassment and concealment of important information when family members or friends interpret, while others describe patient preference for use of a friend or relative.

Another study reported that patients had higher levels of satisfaction with simultaneous remote interpretation assistance compared to face-to-face consecutive interpretation services.

These findings strongly validate the need for additional research, and may reflect the fact that professionally trained interpreters have not been used as the standard in many studies looking at interpretation and quality or satisfaction.

Although a formal search of studies on translation was not undertaken, a few studies were identified that examined the complexity of translating/interpreting conventional medical terms into other languages or cultural contexts. This issue has significant implications for a variety of issues, including health literacy and choice of terminology, both orally interpreted and translated.

Key Research Questions

The Research Advisory Committee (RAC) identified four categorical areas around which to structure future research efforts on language assistance: impact, cost-related, organizational, and translation research questions.

Impact Research

- What is the impact of different language assistance services on communication, patient and provider satisfaction, service utilization (including screenings, type of services provided, diagnostic procedures, and treatment), follow-up, adherence, errors, and health outcomes? (This question is intended to examine the effectiveness of different types of language assistance services, e.g., bilingual staff and clinicians, professional interpretation, ad hoc interpretation, remote telephonic and video interpretation.)
- Does the impact of interpreter services vary across language or culture?
- Does the acquisition of secondary language skills by health professionals have a desirable and measurable impact on outcomes? What level of proficiency is necessary to conduct basic or complicated medical encounters, and what is the minimal level of training required to reach that proficiency?
- Is there a differential impact between clinicians who simply have language skills and those who have knowledge of cultural issues as well? Does being a native speaker or coming from the same country of origin make a difference?
- What is the impact of untrained interpreters versus trained interpreters on different outcomes? If there are differences in quality between these two groups, do they have a measurable impact on intermediate outcomes (e.g., comprehension, adherence)?
- What is the impact on intermediate outcomes of use of family and friends as interpreters, controlling for language group, patient age, and relationship of the patient to the designated interpreter?
- What is the impact of gender concordance between interpreter and patient on communication and patient satisfaction, and does this vary by ethnic or religious background?

Cost-related Research

- What are the cost-benefits of different types of language assistance services? What are the costs associated with not providing interpreter services?
- What impact does the existence of language assistance services have on selection of providers or plans by patients, and what are the cost implications of that selection?
- In what circumstances is it more cost-effective to employ staff interpreters vs. contract interpreters?
- How do the costs and benefits associated with the provision of language assistance vary across different types of services, institutional settings and geographic locations? Do any differences suggest variable requirements for language assistance?

Organizational Research

- In addition to cost, what other factors affect organizational decisions to use interpreter services?
- At what points of contact (e.g., nurse advice line, appointment making operations, membership services, health promotion programs, medical office receptionists, clinical encounters) does the provision of language assistance (through bilingual staff persons or interpreter services) make a difference to satisfaction, service utilization, follow-up, communication, adherence, errors, and/or health outcomes?
- What are the components of an interpretation services and translation program that improves satisfaction, service utilization, follow-up, communication, adherence, errors, and/or health outcomes?
- Are health care staff more inclined to use staff interpreters, bilingual staff, or outside services such as contract interpreters, remote telephonic or video interpretation? What factors influence decision-making in this area?
- What are the human resource management considerations (including cost) involved in using bilingual staff with other responsibilities as interpreters? Are such staff encouraged or required to be specially trained as interpreters, and what are salary/union contract ramifications?
- What technology or physical plant considerations are prerequisites to implementing an interpreter services program successfully (e.g., telephone wiring in examining rooms, examining rooms large enough to accommodate interpreters)?
- What methods (verbal and written) of notifying patients of their rights to interpreter services are most effective in increasing utilization of interpreter services?
- What other factors are behind the reluctance of clinicians to utilize available interpreter resources and how can these barriers be overcome?
- What financial incentives or changes in reimbursement methods can increase utilization of interpreter services?
- What governmental or accreditation policies are most successful in persuading health care providers to provide language assistance for LEP patients?

Translation and Miscellaneous Research Topics

- Does translated signage improve patient comfort or ability to move through health care facilities?
- Do translated written pre-operative instructions lead to decreased rescheduling of procedures because of inappropriate patient preparation?
- Do translated discharge forms result in a higher rate of attendance at follow-up appointments with either specialists or primary care clinicians?
- Do translated prescription instructions lead to fewer patient medication errors and/or better adherence?
- Are verbal (interpreted) instructions more effective than translated written materials for certain patient groups (by age, ethnicity, or education)?
- Do verbatim translated consent forms vs. summarized consent forms lead to different choices about undertaking high-risk procedures?
- What are the best approaches for communication of written materials with patients who do not read, or who speak a language without a written form?
- How critical is it to accommodate regional or dialectic differences in large language groups (e.g., Spanish, Arabic, Chinese)? How do patients respond to occasional word idiosyncrasies?
- Do patients seek language concordance because they have the choice or because these are the only providers available to them? Do some LEP patients deliberately seek out non-concordant providers and staff based on a perception of higher quality of care?

Methodological Considerations and Barriers to Conducting Research

The RAC felt that the measurement of intermediate outcomes such as communication, patient comprehension, encounter follow-up and adherence, as well as measurement of satisfaction and subjective determinations of health status, was achievable. However, several methodological challenges may make it difficult for research projects to clearly demonstrate a link between language assistance interventions and health outcomes. The population that needs language assistance services has a broad range of health care needs (obstetric care, preventive services, acute care, and care for a wide variety of chronic conditions). Research studies conducted using this heterogeneous patient population are the most likely to be generalizable, but it is difficult to find generic measures of health outcomes that are applicable to all patients and sensitive to clinically important changes in health. Thus, these studies may need to rely mostly on intermediate outcomes. In addition, studies should be conducted among patients with well-defined conditions (e.g., asthma, heart disease). Studies of narrow patient populations are the least likely to be generalizable, but this approach allows the use of condition-specific health status measures that are more sensitive for detecting clinically important changes in health.

There was a strong consensus from the RAC that research in this area has been hampered by several factors:

- Difficulty of designing experimental studies because of ethical issues such as creating a comparison group for whom interpretation is not provided. This could be overcome by conducting before and after studies in institutions planning implementation of a new interpreter service.
- Lack of funding for large-scale studies that would permit a well-designed, controlled trial of language assistance.
- Limited or non-existent use of standardized definitions of the term interpreter and translation. In order to conduct broader organizational comparisons, reliable and valid measures of interpretation quality will need to be developed. A review of the practices of organizations implementing these services may assist in the identification of effective measures.
- The need for national studies, large government databases, and health care organizations/plans to collect data on the primary language of patients and interpreter service use.
- Difficulty getting smaller studies published because of lack of understanding among reviewers of issues described above.

IV. CATEGORY C: ORGANIZATIONAL SUPPORTS FOR CULTURAL COMPETENCE

Organizational supports for cultural competence encompass activities that can be undertaken at the organizational level to support the delivery of cultural competence interventions. (For details about the organizational supports, consult the text, commentary, and discussion on CLAS standards 8-14 in the CLAS Standards Report (U.S. Department of Health and Human Services Office of the Secretary, 2000).) They may be prerequisites to implementing other CLAS interventions, and are necessary if the organization as a whole is to be culturally competent. Methodological and/or policy considerations affecting future research will not be discussed separately for each organizational support, but will be discussed for all organizational supports at the end of this section.

Because implementing these types of activities requires considerable effort and resources from health care organizations, there is a natural desire to know whether taking these steps has a positive impact on the efficient implementation of cultural competence interventions, patient and staff satisfaction, appropriate utilization of services, the cost-effectiveness of services, the quality of services, and other desirable effects. However, it may be that organizational supports should only be evaluated for their impact on the effectiveness and efficiency of clinical cultural competence interventions, not on patient outcomes, since their primary purpose is to improve the infrastructure of the organization and patient outcomes are too far removed.

State of the Literature

Many cultural competence supports have been implemented in a variety of different types of health care settings. Some of those organizations have conducted basic evaluations of their programming, and others need assistance from researchers to design and develop evaluations or outcome studies. At this time, very little published research has been identified that specifically examines the processes and outcomes of organizational supports for cultural competence. The literature describes single activities (as opposed to multi-element, systemic interventions) that can be institutionalized at an organizational level, such as the development of information systems, the implementation of training, or the recruitment of diverse staffing. A brief synthesis of the literature for each organizational support on which literature could be located is listed below. Most of the discussion, however, outlines areas of research that might help us better understand the benefit of these accommodations.

Research Agenda on Management, Policy and Implementation Strategies to Institutionalize Cultural Competence Activities

Definition

Management, policy, and implementation strategies to institutionalize cultural competence activities include written organizational strategic plans that outline clear goals, policies, operational plans; initial and ongoing organizational self-assessments of cultural competence-related activities; and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Synthesis of Findings from Literature Review

The literature consists primarily of descriptions of different approaches to implementing cultural competence activities in an organization, with very little analysis of outcomes. Two studies examine the different factors and forces that led to successful and unsuccessful implementation of cultural competence interventions.

Key Research Questions

In general, more documentary evidence is needed of the step-by-step processes of implementing cultural competence activities, as well as evaluations of what processes are more successful than others. Further work investigating the barriers and supports for successful implementation programs is also necessary. Other issues worth investigating include:

- What factors or forces encourage management to commit to cultural competence (e.g., regulatory, community pressure, staff pressure, and market-expansion aspirations)? How does cultural competence get adopted into the organization through non-management channels (e.g., staff-driven efforts to implement discrete activities in a piecemeal approach)?
- Under what circumstances is the centralization of responsibility for the organization's cultural competency more/less effective than decentralized approaches? At what levels of an organization, if any, is staff responsible for cultural competency in the organization more effective than tasking cultural competency to staff with other duties?
- What are the barriers or limitations to the adoption of cultural competence strategies (e.g., cost, time, resource allocation, staff, and lack of expertise)? What is required to overcome these barriers?
- Does the existence of explicit plans and strategies for the implementation of cultural competence interventions facilitate and improve the delivery of those services over an ad hoc approach?
- Are there any organizational preconditions or critically necessary management or policy components required for the successful implementation of desired interventions?
- What impact does the implementation of organizational self-assessment have on: staff awareness of cultural competence and the needs of culturally diverse populations, motivating improvements on cultural competence within the organization, improving the quantity and quality of culturally competent services over time, and overall organizational strategic planning?
- Do organizational cultural competence assessment tools have to be organization-specific (e.g., for hospitals, health plans, community health centers) or can they be generic?
- Can instruments be designed to reliably compare cultural competence across organizations?
- Should assessment tools measure the ability to provide CLAS to specific ethnic/cultural populations, or should it measure the ability to serve diverse groups?

Research Agenda on Community Involvement in Cultural Competence Program Planning, Design, Implementation, Governance, Training, and Research

Definition

Community involvement includes participatory, collaborative partnerships with communities, and formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing cultural competence-related activities.

Synthesis of Findings from Literature Review

Many stakeholders have postulated that involving ethnic communities in the design of programs will lead to higher satisfaction with and better utilization of services. Community input mechanisms that have been described in literature include surveys, telephone and in-person interviews, focus groups, community meetings, community advisory committees, community members on standing organizational committees, and community member participation in program design and evaluation committees.

For discussion of the relevant literature, see Category A—Research Agenda on Family/Community Inclusion in Health Care Delivery and the below Research Agenda on Design and Use of Surveys and Profile Instruments to Plan for Services and Measure Satisfaction and Quality.

Key Research Questions

- What are the desirable, measurable outcomes of obtaining community input at the organizational or programmatic level? Which outcomes benefit the users of services or the community, and which benefit the organization? What mechanisms for obtaining input maximize which outcomes?
- Does having ethnic community advisory committees or other mechanisms of community input have a measurable and beneficial effect on the successful implementation and acceptance of plans, policies, and programs of culturally competent interventions, either at the organizational or programmatic level?
- What are effective models for soliciting input to inform organizational strategic planning?
- To what extent is community input used in subsequent decision-making processes?
- Does the existence of community input mechanisms improve the perception of a health care organization among the community and/or result in increased health care-seeking behavior or utilization of services?
- What are the best ways to obtain fair representation in community participation activities of the different communities that the organization serves? What methods are useful for supporting ongoing involvement by consumer representatives?

Research Agenda on Design/Use of Surveys and Profile Instruments to Plan for Services, and Measure Satisfaction and Quality

Definition

Surveys and profile instruments can be integrated into internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Synthesis of Findings from Literature Review

Several descriptive studies examine multifaceted processes of developing survey instruments that are culturally appropriate for the purposes of gathering information to design and deliver health services. Quantitative and qualitative methods are used to gather relevant cultural information for the purposes of survey design, pilot testing and modification of the tool. Collaboration with communities in developing instruments was described in some of the studies.

Key Research Questions

- What kinds of survey information do organizations need to monitor the impact of culturally appropriate programs and systems?
- How are valid tools developed to gather information on patient satisfaction, given the difficulty of reliably measuring satisfaction across ethnic groups?
- What level of community input, data gathering and testing is necessary to develop culturally valid tools for information gathering, as many health care organizations have neither the time nor resources to engage in complex survey development processes for the purposes of service planning and design? Are there model instruments or templates that can be easily adapted? What are the benefits of the *process* of involving the community in survey design, above and beyond implementing an acceptable tool?
- Does the availability of cross-cultural health information systems result in beneficial utilization by providers and patients? Is this information incorporated into practice or behavioral change? What information delivery systems are most acceptable and most reliable?
- What are best practices in providing information about cross-cultural health care and cultural competence issues for everyday use by providers and staff? What kind of content is likely to be accessed on a regular basis? What training is needed for such a database to be utilized? Should it be a stand-alone system or incorporated into other information systems?

The following topics were not included in the original literature search. However, research questions are discussed on the following pages.

Research Agenda on Cultural Competence Self-Assessments and Ethnic Data Collection/Community Profiles

Definition

Cultural competence efforts are built upon an understanding of what populations a health care organization is serving. *Ethnic data collection* and the development of *community profiles* are thought to be an important cornerstone for cultural competence planning. Data collection includes documenting patient/consumer race, ethnicity, and spoken and written language in health records; integrating these data into the organization's management information systems; and periodically updating them. Data collection at the community level includes demographic, cultural, and epidemiological profiles of the community as well as needs assessments to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Key Research Questions

- What impact does the implementation of organizational self-assessments have on: staff perception of cultural competence and the needs of culturally diverse populations; motivating improvements on cultural competence within the organization; improving the quantity and quality of cultural competence services over time, and overall strategic planning?
- What remains to be done to develop valid and reliable instruments to assess organizational cultural competence?
- Is it possible and/or desirable to develop instruments that compare cultural competence across organizations, or do we want to simply be able to measure cultural competence within a single organization?
- What replicable models exist for the collection of race/ethnicity/language (r/e/l) data? Who should be involved in the planning of data collection systems? Who should be trained to collect such data?
- What adjustments to management information systems are necessary to integrate r/e/l data with other institutional data that would reveal trends in health status and health care delivery outcomes?
- How can the reliability of data collection on providers be improved (e.g., the accuracy of provider self-reports on language proficiency)?
- What are the resistance factors to providing, collecting and utilizing r/e/l data among both patients and health care providers? Are there ways these concerns can be allayed? What type of training and/or information is needed to improve attitudes and practices towards data collection practices?
- What level of detail related to r/e/l data is needed to adequately plan for and monitor the delivery of culturally competent services in health care organizations? (E.g., how many Arabic interpreters are needed? How many African-American clinicians should be in my network? Should a special PAP smear outreach program be developed for Vietnamese women?)
- What is the impact of the absence of formal policy related to r/e/l data collection at the time of enrollment and/or clinical care intakes?

- Does the easy availability of r/e/l data improve the timely delivery of culturally competent services, such as insuring an interpreter is present for appointments, sending materials in the appropriate language, or assigning enrollees to a concordant clinician if the enrollee doesn't select a clinician?
- How do patients use r/e/l data in selecting providers? Does that choice result in better outcomes? Does it result in adverse selection problems for providers?

Research Agenda on Culturally Appropriate Ethics, Conflict, and Grievance Resolution Processes

Definition

Ethics, conflict, and grievance resolution processes that are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers are important for equitable treatment of minority patients/consumers.

Key Research Questions

- What models exist to facilitate the discussion and resolution of culture-related conflict situations, and are they culture-specific or usable generically across multiple ethnic groups?
- How can staff be best prepared for dealing with these situations in a way that minimizes the danger to clinician-patient trust, and what institutional policies work best to support staff and patients, especially in environments where many cultures are being served?
- Does the existence of culturally sensitive ethics, conflict, and grievance resolution systems prevent or improve the resolution of culturally based conflicts?

Research Agenda on Public Information about CLAS Standards Performance

Definition

Public information about progress on and successful innovations in implementing the CLAS standards, and public notice in communities about the availability of this information, can provide incentives to health care organizations to put a priority on cultural competence.

Key Research Questions

- What kinds of information do ethnically diverse populations want, need and use to make decisions about choosing health care providers and health care organizations? What types of information do purchasers want?
- Do issues of cultural and linguistic competence enter into decision-making processes?
- How can this information best be presented for different audiences?

Research Agenda on Implementation of all the CLAS Standards as a Comprehensive Organizational Strategy

Definition

The CLAS standards can function effectively as individual standards or as a comprehensive strategy to improve cultural competence across all facets of an organization. *Implementation of all the CLAS standards as a comprehensive organizational strategy* may produce greater impact than implementing the standards individually.

Key Research Questions

- What is the financial cost of implementing a comprehensive, organization-wide approach to cultural competence, such as described in the CLAS standards (including a determination of administrative burdens)?
- What is the administrative burden of putting these standards in place? Are there other non-cost barriers to accepting the implementation of CLAS activities?
- Will integration of standards put an organization into a deficit position or does non-compliance put an organization into a deficit position?
- Can cultural competence be integrated into other efforts rather than exist as a competing effort?
- What can be learned about incentives/barriers to compliance with other regulatory measures to change provider behavior (e.g., the Emergency Medical Treatment and Active Labor Act) that might be applicable to successful implementation of the CLAS standards?

Methodological and/or Policy Considerations Influencing Future Research

Studies of organizational interventions must compete with clinical studies for the research resources. Because clinical research has a more obvious direct impact on patient outcomes, both organizations and funders have favored it over research on organizational interventions. Most organizations that have implemented organizational interventions have done so because they believe in their effectiveness and are not inclined to produce evidence that they indeed work. Education and incentives may be needed to persuade health care organizations to test organizational interventions.

With respect to the types of studies that could be conducted, there need to be more comparisons of outcomes between organizations that do implement organizational supports for cultural competence and those that do not. Design issues will be complicated by the fact that many of these supports are not implemented in isolation but several at a time, and determining what intervention is responsible for what effect will be difficult, as will isolating other confounding variables. It will also be difficult to conduct studies that require large sample sizes because of the limited number of institutions involved in implementing organizational supports for cultural competence.