

Part One

INTRODUCTION AND KEY FINDINGS

I. INTRODUCTION

Context of Diversity and Cultural Competence in Health Care

The steadily increasing diversity of the United States affects health care providers and institutions, from small rural towns to large urban centers. The impact of this diversity means that every day, health care providers encounter, and must learn to manage, complex differences in communication styles, attitudes, expectations, and world views. Decades of literature from the social and clinical sciences have documented the details, effects, and potential remedies to issues that arise when different cultures encounter each other.

Health care providers take many different approaches to bridge barriers to communication and understanding that stem from racial, ethnic, cultural and linguistic differences. In recent years, the notion of *cultural competence* has come to encompass both interpersonal and organizational interventions and strategies that seek to facilitate the achievement of clinical and public health goals when those differences come into play.

There have been many attempts to describe and quantify cultural competence in health care. These include formal definitions; model programs; laws, regulations, and standards; performance measures and other evaluative criteria. But what does cultural competence actually *accomplish*? Does it make a difference to patients and to health care delivery and health outcomes? This project looks at the question of what impact cultural competence interventions have on the delivery of health care and health outcomes, and investigates the opportunities and barriers that affect how further research in this area might be conducted.

The CLAS Standards and Cultural Competence Research Agenda Projects

This document is the final report for the Cultural Competence Research Agenda project, sponsored by the U.S. Department of Health and Human Services Office of Minority Health (OMH) and Agency for Healthcare Research and Quality (AHRQ) to examine how cultural competence affects health care delivery and health outcomes. It completes a process begun in 1998 with the OMH-sponsored development of national standards for culturally and linguistically appropriate services (CLAS) in health care. The CLAS standards were published in the *Federal Register* in December 2000 (U.S. Department of Health and Human Services Office of the Secretary, 2000), and have become the basis for subsequent government and private sector activities to define, implement, and evaluate cultural competence activities among health care providers.

The CLAS standards were initially derived from an analysis of current practice and policy on cultural competence, and further shaped by the input and expertise of health care providers, policymakers, researchers, advocates, and consumers. The 14 standards are organized by themes: Culturally Competent Care (standards 1-3), Language Access Services (standards 4-7), and Organizational Supports for Cultural Competence (standards 8-14). Standards 1-7 address interventions that have the most direct impact on clinical care; and standards 8-14 address organizational structures, policies and processes that support the implementation of standards 1-7.

The CLAS standards were developed to provide a common understanding and consistent definitions of culturally and linguistically appropriate services in health care. They are intended to offer a broad and practical framework for the implementation of services and organizational structures that can help health care providers be responsive to the cultural and linguistic issues presented by diverse populations. While

aimed primarily at health care organizations, individual clinicians are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services.

It was the understanding of the CLAS standards sponsors that wide adoption of cultural competence activities, as described in the standards, would ideally be supported by research that makes a link between the performance of those activities, improved health care delivery and better health outcomes. Many health care providers and policymakers have fundamental questions about the intrinsic and relative value of different cultural competence methods and programs. These questions may relate to:

- *Access and outcomes* (which interventions increase access for culturally and linguistically diverse populations to health care services and/or improve their health outcomes?)
- *Quality and reduction in errors* (which interventions increase the provision of appropriate care to and/or reduce the incidence of medical errors among diverse populations?)
- *Cost* (which interventions are cost effective—e.g., reduce diagnostic testing and emergency room use or increase preventive services lowering future health costs?)
- *Comparative analyses* (which approaches or interventions work best under which circumstances?)

OMH and AHRQ sponsored the development of a health services research agenda on cultural competence in health care to promote the creation of an evidence base that would address these questions.

Objectives of Cultural Competence Research

How best to pursue further research on cultural competence interventions depends greatly on the kinds of questions stakeholders want answers to. Different stakeholders may have different informational needs, and these needs, while convergent at times, may vary in the order of importance from one stakeholder group to the next.

For example, basic definitions and parameters are needed for every category of cultural competence intervention. These definitions are critical, not only to support basic program design and evaluation, but also to facilitate the evaluation of additional research on outcomes where standard definitions are necessary for comparability of results. Research required to produce these definitions and identify the standard elements of interventions is not methodologically difficult, but some stakeholders may perceive this work as less important because it does not directly address outcomes that are more important to them. It is likely that this type of research will be of greatest interest to those attempting to standardize interventions for the purposes of quality control; regulators and standard setters; individuals who design and implement cultural competence interventions; and investigators who need standard definitions for conducting cultural competence research.

Stakeholders who are primarily interested in the success of the clinical encounter (e.g., patients, families, and clinical staff), may have more interest in the impact that cultural competence interventions have on what are often called intermediary outcomes (e.g., comprehension, satisfaction, adherence to medication and lifestyle recommendations, appropriate utilization). Those who pay for health care are especially interested in how cultural competence interventions affect utilization of services. Because of the large number of potentially confounding variables, it is very difficult to show a direct link between a cultural competence

intervention and health status improvements and/or cost savings. It may be, however, possible to link together a number of intermediary outcomes that contribute to health status improvements and/or cost savings. For example:

CLAS → better communication (measured by comprehension, satisfaction, etc.)
 → better adherence to medications and lifestyle changes
 → improved health status
 → lower undesirable health care use (ED visits,
 hospitalization, etc.)

To integrate multiple perspectives, the project team applied a common set of outcomes research questions to cultural competence interventions to develop a research agenda that cuts across stakeholders' interests.

Did the intervention do what it was supposed to do?

For example:

- Did provider knowledge/awareness improve after training?
- Did patients in need of culturally competent services receive them?
- Were written translations understandable?

Did the intervention affect processes of care?

These might include:

- Provider behavior modification
- Patient comprehension, participation in communication, treatment negotiation
- Time spent with the physician
- Diagnostic accuracy

Did the intervention improve access to services and/or appropriate utilization of services?

Measures might include:

- Receipt of diagnostic tests, appropriate medications, preventive/specialist services
- Number of admissions
- Hospital days, length of stay, bounce-back/recidivism
- Preventable hospitalization
- Inappropriate usage of services (e.g., ED)
- Most-to-least restrictive setting progression
- Error reduction and/or patient safety
- Medication errors, inappropriate treatment, unnecessary procedures

Did the intervention affect patient satisfaction and health behaviors?

Other measures might include:

- Patient trust
- Acceptance of preventive services

- Adherence to medications, appointments, lifestyle change recommendations
- Patient loyalty
- Health seeking behavior

Did the intervention affect patient health outcomes?

These might include:

- Better control of chronic disease symptoms
- Improved health status:
 - Self-report
 - Established medical outcomes
- Quality of life
- Population-based/community-level indicators:
 - Morbidity, mortality
 - Prevalence/incidence of disease
 - Level of acuity

Did the efficiency and cost-effectiveness of health care delivery change?

For example:

- Does it take more time to use a trained vs. untrained interpreter?
- Did the intervention reduce inappropriate care, resulting in cost savings?
- Did the intervention increase preventive care/early intervention that reduced treatment costs?

Contrary to popular perception, research in many of these areas has begun and is of growing interest to the health services research community. Much of this work looks at the impact of attempting to improve communication between clinicians and patients when cultural or linguistic factors are involved. However, further work is needed to raise awareness about the existing evidence base on cultural competence interventions, and to promote continued research in this area. Advancing a cultural competence research agenda involves many tasks. Specific research questions need to be identified. Funding must be made available for this research. A cadre of interested researchers needs to be cultivated and networked. Data sets need to be identified and analyzed. Most importantly, the results of research must be made widely available to practitioners, policymakers, and other researchers.

Another important task, given the limited resources available for research on cultural competence interventions, is improved information-sharing about research projects to share research instruments and methods, promote collaboration, avoid duplication, and maximize limited funding. While no single study is definitive and additional research is always needed to confirm the validity of initial studies, better awareness of, and coordination of efforts, could advance critical areas of research more efficiently.

Recently published studies reinforce the intuition that a lack of attention to cultural issues leads to less than optimal health care, and that addressing these concerns or using certain cultural competence interventions leads to improved outcomes. This research does not exist for every population or every type of cultural competence intervention—most of it is concentrated on the impact of language or communication barriers—but it is sufficient to suggest that additional work in this area is warranted.

II. OVERVIEW OF THE CULTURAL COMPETENCE RESEARCH AGENDA PROJECT

Project Goals and Objectives

The main goal of the Cultural Competence Research Agenda Project is to produce and disseminate to key stakeholders a research agenda on the relationship between cultural competence interventions and health care delivery and health outcomes. This goal has been accomplished through completion of the following tasks:

- Developing a working consensus on the parameters and specifics of cultural competence interventions for the purposes of conducting health care delivery and health outcomes research.
- Collecting, reviewing and making available to the public abstracts of published, unpublished, and in-progress research on cultural competence.
- Identifying key research questions on cultural competence that have been the subject of research, and describing the strengths and limitations of this research.
- Identifying key research questions on cultural competence that have yet to be studied.
- Identifying issues related to study design, potential data sources and study sites.
- Identifying larger contextual issues related to cultural competence research: how to interest potential researchers, linking content experts with research experts, researcher collaboration/networking, funding for research, publication, and how to involve and gain the support of research stakeholders (providers, policymakers, consumers) in the identification and utilization of research findings.

Project Methodology

Preparing the cultural competence research agendas involved a multi-step process: 1) conducting a literature review, 2) convening a Research Advisory Committee (RAC), and 3) drafting, soliciting comments on, and revising the research agenda.

The project was guided by the following definition of cultural competence used in the CLAS Standards Report (U.S. Department of Health and Human Services Office of the Secretary, 2000).

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Conduct Literature Review

A multi-source, first-run literature search was conducted to identify research that used empirical analysis to measure the impact of culturally and linguistically competent interventions on outcomes, specifically issues

related to access, utilization and health status. A substantial number of published studies in this area document racial and ethnic health disparities, present arguments for integrating culturally competent interventions, or describe models and methodologies. However, the goal of this search was to quantify and analyze the research base where the primary focus is the measurement of the impact of the intervention.

The project team developed a key word template consisting of approximately 177 terms and word combinations using as a framework the cultural competence interventions listed in the CLAS Standards Report (U.S. Department of Health and Human Services Office of the Secretary, 2000), supplemented by interventions cataloged by Brach and Fraser (2000). The CLAS Standards Report describes 14 actions that can be taken by health care organizations to improve cultural and linguistic competency; Brach and Fraser sets out nine interventions that could be used to reduce racial and ethnic health disparities. The list of cultural competence interventions can be found at the beginning of Part Two of this report. A complete list of search terms used can be found in Appendix One.

The template was applied to major literature databases, including MEDLINE® (1966-2001), CINAHL® (1982-2001), PsycINFO (1987-2001) and Sociological Abstracts (SOCA)/Sociofile (SOCIO) (1963-2001). In an attempt to identify additional research, publications, or projects relating to cultural and linguistic competence, a Web site search was also conducted. This entailed the review of 38 private foundations currently funding public health and health services initiatives, 58 health policy organizations and associations, and the government Web sites of all Federal health and human services agencies and bureaus. Information about unpublished studies and research in progress was gleaned from these sources and also from the project Research Advisory Committee and other individuals interested in research on cultural competence.

Convene Research Advisory Committee

A Research Advisory Committee (RAC) of key researchers, policymakers and health care providers was convened to review the literature and make recommendations for a research agenda to pursue work in this area. The 30-member RAC met in Washington, DC in April 2001 for a two-and-a-half day meeting to review the analysis of the literature on cultural competence and outcomes. The RAC was divided into three groups according to interest area and expertise to develop research questions for their topic areas and discuss methodological concerns related to conducting research in that area. The group also met as a whole to discuss overarching issues related to the definitions, study design, and funding/publication challenges of cultural competence research, which are described in Part Three of this report. A complete contact list of the RAC members, along with select meeting materials, can be found in Appendix Three.

Draft, Solicit Comments on, and Revise Research Agenda

Drawing on the RAC's recommendations and findings from the literature review, the project team prepared individual research agendas for each of the main topic areas. The draft agendas were sent to RAC members for comment. Public comment was solicited by posting the draft agendas on the DiversityRx Web site (www.diverstyRx.org/rcproj1) and circulating them to the National Council on Interpretation in Health Care LISTSERV®. The draft agendas were revised and the final versions are contained in Part Two of this report.

Highlights of Literature Review Findings

The literature review revealed a considerable amount of descriptive literature on each of the interventions. Although this information does not present a scientifically based argument for the use of most of these interventions, it supports the initiation and continuation of research in this area. Additionally, the value of descriptive literature should not be overlooked in the research development process. Descriptive information can provide the foundation for model duplication, identification of best practices, meta-analysis, identification of standard measures and instruments, hypothesis generation and further empirical research.

This search uncovered only a limited number of published studies for each of the interventions that employed rigorous research methodologies, and these are described in more detail in the literature analyses and matrices contained in Appendix Two and the abstracts contained in Appendix Four. Some of the well-established, non-cultural competence specific-approaches, such as health promotion and education, have, through an evolutionary process, incorporated certain elements that enhance outreach efforts and service delivery to multicultural communities. In these instances, the descriptive and empirical research base was substantially larger than some of the more recently recognized interventions such as cultural competence training.

Although limited in scope and depth, the body of existing empirical studies does suggest that several of the proposed interventions have the potential to affect health care delivery and health outcomes. Culturally sensitive interventions such as cultural competence training and racial and ethnic concordance have shown improvements in subjective, self-assessed measures of provider knowledge and patient satisfaction. Health promotion and education programs that utilize interpreters, community health workers, translated materials and other culturally sensitive approaches reported increases in intake, program completion, and knowledge.

Studies examining the impact of community health workers and traditional healers were almost non-existent compared to the large volume of descriptive literature detailing the use of these practices. Studies examining the impact of linguistic and communication interventions on outcomes were found to have different degrees of effectiveness on patient satisfaction and health services utilization. No literature was identified that specifically examined both the processes and outcomes of organizational accommodations for cultural and linguistic competence.

In sum, the literature reveals promising trends in outcomes-related research that should be further explored. Certain cultural competence interventions appear to affect health services utilization, satisfaction, and increases in knowledge, although subsequent impacts on provider or patient behavior and/or health outcomes were not explored. Some studies that measured outcomes for specific interventions revealed contradictory and inconclusive results, due to significant variations in definitions, study design or approach. Their findings cannot be easily generalized, further supporting the need for additional research. Clearly, the results of this literature search demonstrate an opportunity to further build an evidence base linking cultural competent interventions to specific impacts on outcomes.

Additionally, future literature reviews that search for specific outcomes may result in a more comprehensive set of literature findings. However, this would require significantly more searches and review time and a clear definition of outcomes being sought. There are many outcomes that could be examined such as health services utilization, satisfaction, compliance, health knowledge, communication, improved health outcomes, etc. However, it may be very difficult to identify and link specific interventions and approaches to these improvements. It may also be difficult to link interventions of integrated culturally sensitive approaches to positive outcomes if those interventions were not the main focus of the study.

Highlights of the Research Agendas

The successes and limitations of the existing impact literature on cultural competence point to substantial opportunities for future research in each of the identified categories. Using both descriptive and quantitative approaches, this research can further illuminate the details of cultural competence interventions as well as specific impacts on health care delivery outcomes.

The major task of this project was to propose future research directions in the area of cultural competence and health care delivery and health outcomes. By analyzing the literature, the project team was able to identify areas where the current research was weak or lacking, and suggest areas and questions for further exploration. These efforts were buttressed by the discussions and recommendations of the RAC, both during the April 2001 RAC meeting and in subsequent reviews of the research agenda drafts.

The major product of this endeavor is the group of research agendas found in Part Two of the report. Each research agenda contains a definition of the category, a brief synthesis of findings from the literature, key research questions, and a discussion of methodological and policy considerations influencing future research for that area.

The research agendas reflect that some of the topic areas were backed by a greater body of literature and/or generated more interest from RAC members. The extensive agenda developed for the language assistance interventions category mirrors its prominence among both health care providers and policymakers. It is also the agenda best supported by previous research related to outcomes. Additional topics generating significant interest included cultural competence education and training, and racial, ethnic and linguistic concordance. The topic of organizational supports generated a broad list of questions, although the majority of these focused on their effect on the processes of health care delivery and not on health outcomes.

It is interesting to note that as stakeholder interest and investment in implementing certain interventions increases (e.g., interpreter services, hiring for diversity, cultural competence training), so too does the demand for concrete linkages between an intervention and outcomes, especially cost-related benefits.

Conversely, there are many providers who are willing to undertake these interventions without “proof of value,” perhaps simply due to consumer demand for such interventions or because the face value of the intervention is obvious. Many RAC members pointed out that, methodological and funding challenges aside, the importance of outcomes research on cultural competence interventions should not be overstated, given that many cultural competence interventions have already been implemented despite the lack of rigorously conducted, definitive outcomes studies.

The following highlights of the Cultural Competence Research Agenda are organized into three groups of cultural competence interventions:

- Category A: Culturally Sensitive Interventions
- Category B: Language Assistance
- Category C: Organizational Supports for Cultural Competence.

A complete list of research questions can be found in Part Two of the report.

Category A: Culturally Sensitive Interventions

Cultural Competence Education and Training

Among the activities listed under Category A, cultural competence education and training generates considerable interest among providers, educators, and policymakers for its potential impact on improving the patient-provider relationship when cultural differences exist. While the descriptive literature on this topic is extensive, studies that examine the impact of training on either trainees and patients is more limited. Some connections are made with increases in levels of cultural knowledge, attitudes and awareness, and improvements in communication skills among trainees. Few studies examined the impact of training on health care delivery, patient behavior change, or health outcomes. The topic and the literature, however, were sufficient to inspire a substantial number of future research questions. These include questions that seek to better understand and define the intervention related to:

- Trainees and motivation (e.g., what incentives are sufficient to motivate clinicians to undertake cultural competence training—improved patient-provider relationship, improved health outcomes, financial rewards?)
- Content of training (e.g., what competencies and basic skills produce behavioral changes by trainees and improvement in health and health care delivery outcomes?)
- Form of training (e.g., which educational delivery techniques are most effective at changing trainee behavior?)

Another category of questions seeks to measure the impact of training on both providers and patients. These include questions on:

- Achieving behavioral changes among trainees (e.g., 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?)
- Measuring impact on health care delivery and health outcomes (e.g., do patients of providers who have received training show improvements in satisfaction, adherence to treatment recommendations, keeping recommended follow-up visits, etc.?)

Racial, Ethnic, and Linguistic Concordance

The topic of racial, ethnic and linguistic concordance among providers and patients has already generated considerable research interest. 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 concordance appeared to have a positive impact on appropriate service utilization, treatment participation, and receipt of some services. However, the literature on the effects of positive outcomes in utilization was not shown to translate into improvements in health outcomes. Many health care organizations and policymakers have pursued diversification of the workforce as a way of increasing patient-provider concordance, although others are skeptical, given the demographic difficulties of achieving this goal across-the-board. Nevertheless, ongoing research in this area can also be of considerable value for what it illuminates about cross-cultural health care encounters. Key research questions focus on:

- Concordance and the clinical encounter (e.g., what can we learn from concordant encounters about factors that could be emulated in non-concordant encounters?)

- Patient-related health care delivery and health outcomes (e.g., does concordance affect patient/consumer comprehension, satisfaction, appropriate utilization of services, adherence to treatment, perceived health status and/or quality of life measures?)
- Clinician-related outcomes (e.g., 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.)
- The impact of concordance on organizations (e.g., does the overall level of staff awareness and sensitivity to cultural issues improve when there is diversity throughout the organization?)

Community Health Workers and Culturally Competent Health Promotion

Both these topics have already been extensively researched, although not necessarily with a specific focus on the effect of the culturally competent aspect of the interventions. Studies suggest linkages between the intervention and increases in health-care-related knowledge, self-care practices, screening rates, and decreases in risk behaviors. Both types of interventions could benefit from further research in the following areas:

- What is the impact on knowledge, behavioral change, and/or health outcomes of community health workers (CHW) and culturally competent health promotion (CCHP) programs versus standard interventions? Versus no intervention?
- Is there a significant improvement in health care delivery and/or health outcomes when the intervention is highly tailored to subgroups and subcultures as opposed to generalized culturally competent health promotion programs?
- Which elements of the culturally sensitive methods utilized by CHW and CCHP programs improve access, quality and utilization of services?

Category B: Language Assistance

Language Barriers, Bilingual Services, Oral Interpretation, and Translated Written Materials

The literature on the impact of language barriers and language assistance interventions is both substantial and promising with respect to outcomes. Studies show that language barriers have a demonstrable negative impact on communication, satisfaction, and appropriate health care utilization. A growing body of literature suggests that language assistance interventions such as oral interpretation can have a positive effect on patient satisfaction and comprehension, and improvements on health care delivery measures such as increases in the amount of time spent with patients, reduction in diagnostic testing disparities among English-speaking patients versus limited English proficient (LEP) patients, higher clinic return rates, and increases in primary care services utilization.

The Research Agenda on this topic is divided into four areas around which to structure future research efforts on language assistance:

- Impact research (e.g., what is the impact of untrained interpreters versus trained interpreters on different outcomes?)

- Cost-related research (e.g., what are the cost-benefits of different types of language assistance services and of not providing interpreter services?)
- Organizational research (e.g., what are the human resource management considerations, including cost, involved in using bilingual staff who have other responsibilities as ad hoc interpreters?)
- Translation and miscellaneous topics (e.g., do translated prescription instructions lead to fewer patient medication errors and/or better adherence?)

Category C: Organizational Supports for Cultural Competence

The research agenda identifies eight types of organizational supports for cultural competence. These are primarily management activities not expected to have a direct impact on health outcomes, but intended to improve health care delivery to culturally diverse populations.

To date, both descriptive and process-related outcomes research on these activities is very limited. However, a number of research questions were identified that would better define these interventions and investigate potential links between them and improved organizational efficiency. They include research related to:

- Management, policy and implementation strategies to institutionalize cultural competence activities (e.g., 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?)
- Community involvement in CLAS program planning, design, implementation, governance, training, and research (e.g., 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?)
- Design and use of surveys and profile instruments to plan for services and measure satisfaction, quality of services (e.g., 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?)
- Cultural competence self assessments (e.g., what impact does the implementation of organizational self-assessments have on motivating improvements on cultural competence within the organization, and overall organizational strategic planning?)
- Ethnic data collection/community profiles (e.g., does the easy availability of race/ethnicity/language 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?)

Summary of Methodological and Practical Considerations

While there is a high level of interest in the results of research on cultural competence interventions, the RAC identified several methodological challenges to conducting such research. These include lack of:

- Standardized definitions of the interventions
- Standardized evaluative measures
- Culturally competent instruments
- Secondary data sources with uniform racial, ethnic, and language data.

An additional challenge is the large sample size that is required to prove that cultural competence interventions are more effective than similar interventions that are not designed to be culturally competent.

The RAC also identified various factors that impede the funding and publication of cultural competence research. RAC members thought that funders and journal reviewers tended to lack familiarity with the impact of language and culture on health care delivery and viewed cultural competence research as marginal and/or high risk. This was thought to make some funders unwilling to expend the amounts of money necessary to show linkages between cultural competence interventions and health outcomes, and journals unwilling to accept manuscripts. Researchers, in turn, may therefore consider cultural competence studies to be a high risk undertaking.

These challenges, as well as the RAC's suggestions for addressing them, are discussed in further detail in Part Three of this report.