

Measurement of Culturally Competent Performance in Health Care

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This paper addresses considerations and solutions in measuring culturally competent performance at the individual, facility, and systems levels in health care, in behalf of reducing indisputable disparities in health care and health status. The perspectives below represent applied policy research perspectives based on the authors' experience in varied real-life care settings. What we intend to convey is that 1) the cultural challenges are real, 2) the conceptual and practical issues can be managed, 3) local solutions for local communities are best, 4) the results can be measured, and 5) advances require sound management structures, practices, focus, and tools.

I. Core Understandings

Before considering the issues of measurement, certain conclusions based on our grounded observations of cultural competency efforts in health care need to be stated.

A. National statistics on disparities are revealing, but do not of themselves identify local causal relationships or applied policy solutions.

We are convinced that the national statistical reports on disparities in health status and health care are real and profound in their implications on the well-being of American citizens and residents. We are happy to see that the ability to disaggregate national population data down to counties, regions, populations, and health-care plans with increasing detail is progressing. This tells us where, how large, and within what populations patterns of disparity are found. It does not tell us the interacting causes of these specific disparities nor identify the solutions at the community or organizational level. In other words, measurement does not immediately define or direct the nature of solutions. Solutions can be as broad as national health insurance and single-payer systems or as detailed as focused outreach into and engagement of the local Eritrean or Ukrainian community. What is most likely is that, depending on the boundaries of the disparity issue one is focused on, there will be multiple interacting causes requiring multiple interacting solutions.

In our work over the last 15 years or so, we have observed many examples of forces that act to produce health-care and health-status disparities at the community/facility level. These observations are grounded in various pieces of applied policy research and practice and are, essentially, independent of the conclusions of national quantitative inquiry. They provide us with a conceptual map of the elements and relationships that combine to create and sustain health-care and health-status disparities. We suggest the need for all of us to distinguish between disparities in health care and disparities in health status, both of

which are critical but need to be separately understood and dealt with, because their root causes, while linked, may, in fact, be different and separately dealt with.

We outline certain factors resulting in disparities in local health care and health status below as placeholders for more detailed discussions. We are not exhaustive in the listing, because we know that most discussions of this subject among knowledgeable insiders at the service provider and community level have an agreeable “yes, but...” quality. “Yes, I agree with you but it is more complicated than you have presented it.”

One particular complication in disparities measurement is the synergy among class (e.g., socioeconomic status), race, and ethnicity. Although this paper cannot explore in depth the historical and political implications of income stratification, it does warrant continuing consideration. Historically, people of color in the United States have experienced discrimination not only in the arena of health care but education, housing, employment, and so on. While the majority of low-income people are white, low-income people are disproportionately people of color and women. Many people of color, activists, and others view the term “poor” as a negatively loaded term and use “low-income” as a more respectful and accurate term; it may not reflect, however, the true misery and relative social powerlessness at the lower rungs of “low-income.”

Because large numbers of people of color occupy the lower levels of the income strata, it is not surprising that those who work in the health-care industry fail to distinguish the differences or frequently make assumptions based on one attribute or the other. The synergy of class, race, and ethnicity underlies a powerful impulse to stereotype and leads to many, many inappropriate and unevidenced health-care programs, outreach efforts, withholding of information from patients, or modifications of clinical treatments.

Finally, the socioeconomic and class structure of the health professions and institutions mirrors the society at large, with largely-white physicians and administrators occupying the highest strata and largely people of color occupying the lowest strata; these differences become manifest in the resulting policies and practices.

Disparities in health care and health status, as measured phenomena across ethnic, racial, and low-income populations and in specific locales, is, in our view, the combined result of many factors. At the *environmental* level, poverty among any ethnic or racial group is unhealthy:

- substandard or overcrowded housing
- unsafe neighborhoods
- higher risk of exposure to toxic waste
- limited access to fresh vegetables and fruits
- less economic security, health insurance, pension benefits
- difficulty in taking time off work for illness or health-care visits
- social stress
- class and racial discrimination
- lack of supportive resources (public safety, schools, transportation services, social institutions, discretionary income) and networks

- community social and economic conditions (local economic climate, seasonal employment, unemployment, underemployment, inter-group conflict)

There are *health-care industry and institutional factors*:

- availability, affordability (e.g., direct costs, premiums, co-pays, and deductibles relative to local wages, employment, and subsidies), range, quality, and accessibility of providers, hospitals, community health centers, clinics, and pharmacies
- race-concordant, ethnicity-concordant, or language-concordant providers
- language barriers
- cultural barriers
- hours open relative to patients' work and life schedules
- physical plant condition
- active and passive racism, differential and stereotypic perceptions and treatment of patients by providers
- effective and ineffective community outreach and engagement
- waiting times
- provider productivity standards

There are *larger state and community factors*:

- availability, accessibility, and affordability of primary or supplemental health-care insurance
- Medicaid and other eligibility rules
- funding patterns and support of the uninsured and underinsured
- contract requirements and compliance auditing
- market conditions as perceived by health-care plans, hospitals, and provider organizations (e.g., attractive and unattractive service populations)

Finally, there are *behavioral and lifestyle factors* that shape health services use and health status at the community and individual level:

- smoking, obesity, substance use and abuse
- exercise
- health literacy
- self-care
- traditional and alternative medicine
- perceptions and use of Western medicine
- ability to be medically compliant
- reliance on hospital outpatient services for routine and preventive care
- reliance on emergency departments for non-urgent care
- knowledge and acceptance of the American health-care system and its practices

In terms of this behavioral category, it is very important to understand those factors that constrain the ability of individual patients and their families to comply with treatment plans that call for alterations in the patient's diet, exercise, reliance on medications, occupational life, daily activities, and social life. Treatment plans may interfere

significantly with patient, family, social, and community life and if they cannot be materially and culturally supported, the patient may not benefit from what is, theoretically, the ideal treatment plan. Treatment plans must take into account and build upon these aspects of the patient's life or the potential health status of the patient will be compromised. This leads us to the need for embedding the understanding of the patient in his/or her family and community life. We have witnessed many examples of this.

It is critically important to remember that patients, whether recent immigrants or long-term settled residents, are shaped not just by their culture, however defined, but also by their *socialization*. That is, patients have been socialized to seek and use health-care resources both in their home countries and in the communities in which they have transited or settled. This socialization is a different experience for very recent immigrants, longer-term immigrants, refugees, settled minorities, inner city populations, rural populations, and so on. In this socialization process, each person has been taught specific current ways to seek and use medical care and medications.

In our judgment, this accounts for some major differences reported by providers providing health-care services to, for example, Ukrainian immigrants and Mexican immigrants. Each has grown up in a different society where medical care and medications are sought, acquired, and used quite differently. Many who have grown up in Soviet-style medicine have been taught to demand health-care services vociferously and continue to do so when seeking care from American providers. Many who have grown up in more Third World international settings tend to not understand why they need prescriptions to obtain antibiotics, why the physicians routinely ask them "hundreds" of questions, and why, when they go to a physician because they are suffering from a viral infection, they go home with neither a shot nor a pill. These are not deep cultural matters but reflect their socialization in the current health-care delivery system of their home countries or areas. Many patients are quite confused, even disoriented, when encountering the American health-care system and its routine practices in their communities.

Thus, as researchers in real health-care settings, we are full of questions and uncertainties about drawing generalizations of very great scale about solutions for very specific populations. We are grateful for all statistical findings but are cautious about drawing large-scale conclusions about direct action solutions at the institutional, community, and individual levels. We concur with Casalino (2005) who writes

In the IOM model of health-care disparities, quite a lot of attention is paid to the individual physician, but virtually none to the organization in which the physician practices. This individual view of quality and disparities is a mistake, if considered to be not only necessary but also sufficient...A more detailed model includes patients, physicians, physician organizations, and processes used by the organization and its physicians. This model takes account of the medical environment and other physician organization -- the organization in which the physician practices. It also explicitly recognizes the possibility that the organization may use organized processes to communicate with the patient during the time periods before and after the face-to-face clinical encounter. The model

also includes the concept that patients' ability to self-manage their medical conditions -- not just the physician's skill in diagnosis and treatment, and not just the patient's adherence to the treatment plan -- is important in producing high-quality of care.

B. Health-care institutions have logics, interests, and organizational priorities often quite distinct from the consumers of their services.

Health-care disparities, health-status disparities, language interpretation services, and cultural competency are most often mingled together as a single challenge. Yet, in order to deal with them, health-care professions, agencies, and institutions tend to operate according to Western models of change -- break the problems down into reasonable sizes, put them into boxes with definitional and operational boundaries, apply scientific and other measurement techniques to each box, and build pilot projects and demonstration projects to test alternative solutions. In this, they reenact Western cultural norms, that is, scientific, logical, deductive, and mechanical and apply them to solve multicultural and transcultural problems..

For certain challenges, such as language interpretation services, such a box-like approach can be productive. For example, language interpretation services do not require a wholesale reconsideration by an institution of its purpose, of whom it serves, and of how it serves them. While implementing a new and wholesale language interpretation service in an institution is organizationally complex, it is also essentially technical or mechanical in nature. Once the institution has decided to create such services, a decidedly political-financial-quality-cultural decision, implementation requires little more than the executive approving a budget, management adopting appropriate policies and procedures, and contracting, training, and delegation flowing from these actions. In this, it is like any other technical or procedural change.

Conversely, the systematic reduction of health-care disparities, health-status disparities, and cultural barriers requires a greater and more detailed understanding of the local root causes of such problems and, essentially, targeted and homegrown solutions for them. While these are national problems, their practical applied solutions are local; national initiatives, such as financing, recruiting, and training, while very supportive and necessary are, generally speaking, insufficient, non-responsive to changing local conditions, and produce long-deferred outcomes for patients.

True cultural competence solutions are very unlikely to fit into any tidy box-like mechanical solutions. Since we argue below that the culture that needs to be dealt with is the culture of medicine and health-care institutions, cultural competency requires more than a new set of skills and techniques but a sea change in the way the institutions see themselves. Cultural competency is a new way of seeing one's own role and work in the community or marketplace one serves and some significant change in the industry, its facilities, and its professions.

The roles of the medical professions and health-care institutions are constantly emerging. Among the major changes over the recent decades have been the *medicalization* of social problems, the *privatization* of public services, and the *corporatization* of health care.

[balance of 40-page paper available on request]