

Linking Cultural Competence Training to Improved Health Outcomes: Perspectives from the Field

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Outline

- ◆ Cultural Competence: The why and what
- ◆ Current Approaches
- ◆ Lessons from the Lens of an Educator
- ◆ Evaluation to Date
- ◆ Linking to Health Outcomes

Cultural Competence: The Why and the What

Disparities in Health Care 2002

Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when confounders controlled for

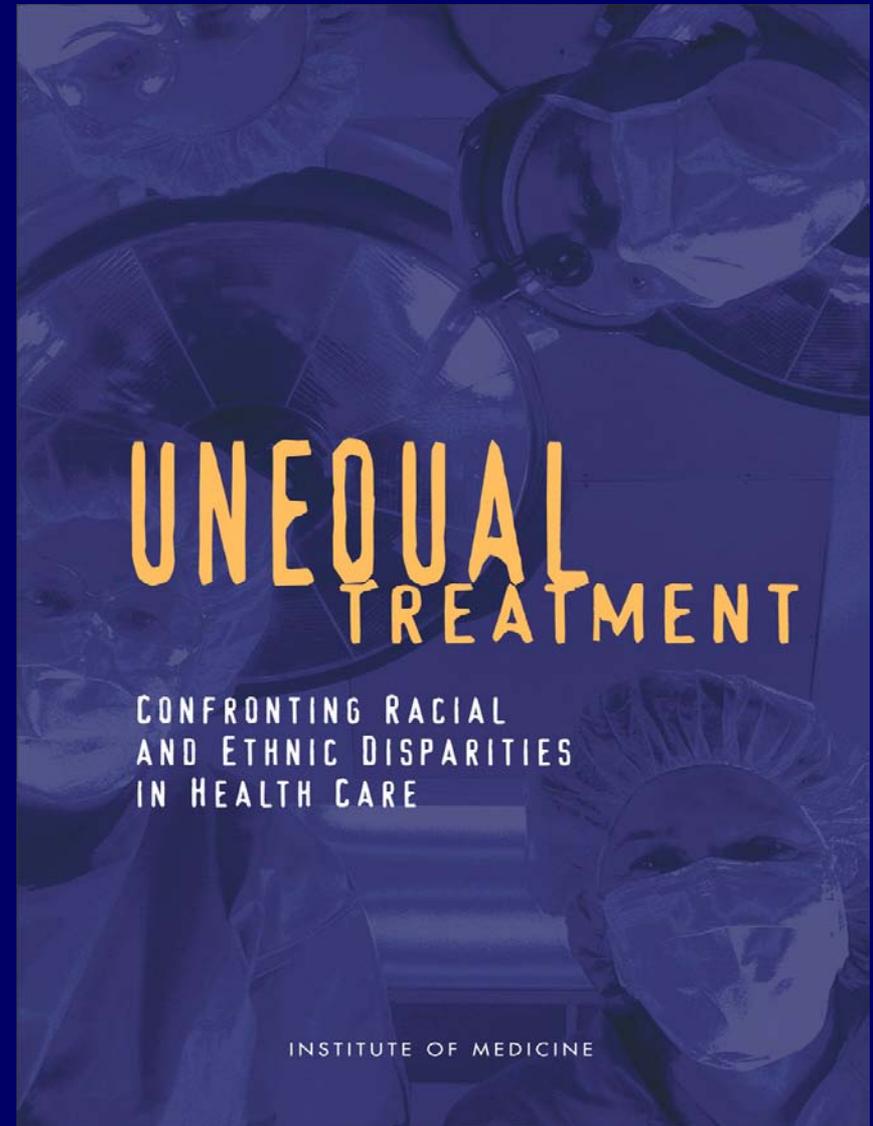
Findings:

Provider-Patient Communication

Stereotyping

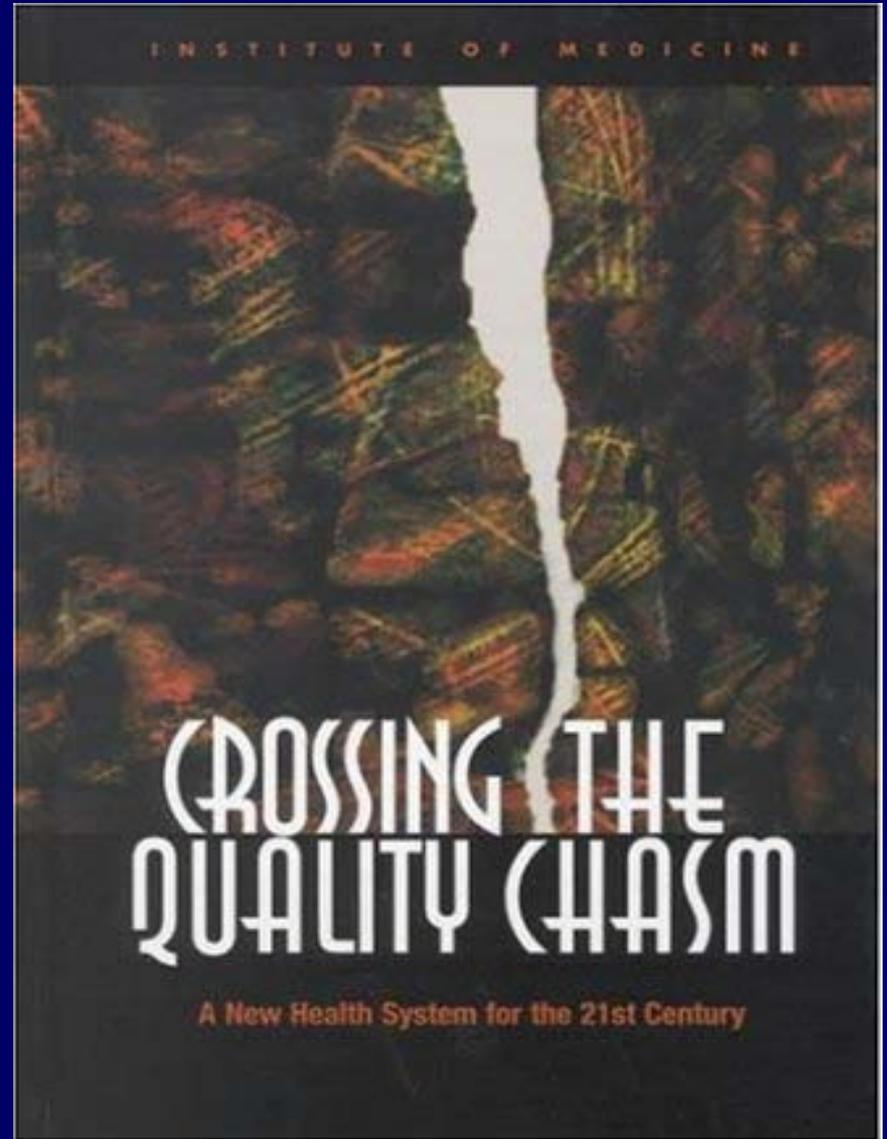
Mistrust

Rec: *Cultural Competence training for all health care professionals*



Quality Health Care

- ◆ Health care should be
 - Safe
 - Effective
 - Patient-centered
 - Timely
 - Efficient
 - Equitable



What is the goal of Cultural Competence?

To improve the ability of health care providers and the health care system to effectively communicate and care for patients from diverse social and cultural backgrounds

Key Principles

- ◆ Culture is broadly defined (not just race/ethnicity)
- ◆ We all have culture
- ◆ There is great variation within cultural groups
- ◆ Cultural competence a process, not an endpoint

Current Approaches

Current Approaches Content and Methods

Three Legs of a Stool

- ◆ Cultural Sensitivity/Awareness Curricula
- ◆ Multicultural/Categorical Curricula
- ◆ Cross-Cultural Curricula

Content and Methods

◆ Cultural Sensitivity/Awareness Curricula

- Primary focus on attitudes
- Exploration and reflection on culture
- Issues of racism, classism, sexism discussed

Content and Methods

◆ Multicultural/Categorical Curricula

- Primary focus on knowledge
- Patients of culture x believe...and behave...
- Previously standard; new focus on community orientation

Content and Methods

◆ Cross-Cultural Curricula

- Process oriented instruction which melds medical interviewing and communication with sociocultural and ethnographic tools of medical anthropology
- Foundation to care for diverse populations; can focus on threshold populations if needed
- Practical tools and skills for clinical practice

Cultural Competence: IOM Key Consensus Areas

◆ Attitudes

- “Buy In”: Establishing impact of sociocultural factors, race and ethnicity on health and health care

◆ Knowledge and Skills

- Disparities and Clinical Decisionmaking
- Core Cross-Cultural Issues
 - ◆ Communication styles, Mistrust, Decisionmaking, Traditions/Customs/Spirituality
- Meaning of the Illness
- Social Context
 - ◆ Support/stressors, language, interpreter use, literacy
- Negotiation

Lessons from the Lens of an Educator

Challenges to Cross-Cultural Education: An Uphill Battle for Learners and Teachers

◆ Learner

- “Soft”, marginalized issues requiring buy-in
- Desire for categorical approach
- Time constraints

**Resistance varies across the continuum*

◆ Teacher

- Varying fundamental approaches and teaching methodologies
- Limited time, funding, institutional support

Strategies for Integration: Five Lessons from the Field

1. “Buy-In” is critical

- Link to quality; curriculum will assist you

2. Focus on cases and clinical applications

- Straight didactics quickly forgotten

3. Address demand for “categorical approach”

- Emphasize pitfalls; development of framework similar to those used in the clinical encounter

Strategies for Integration: Five Lessons from the Field

4. Think longitudinally

- Development of attitudes, knowledge and skills over time, respecting stage of development

5. Integrate when possible

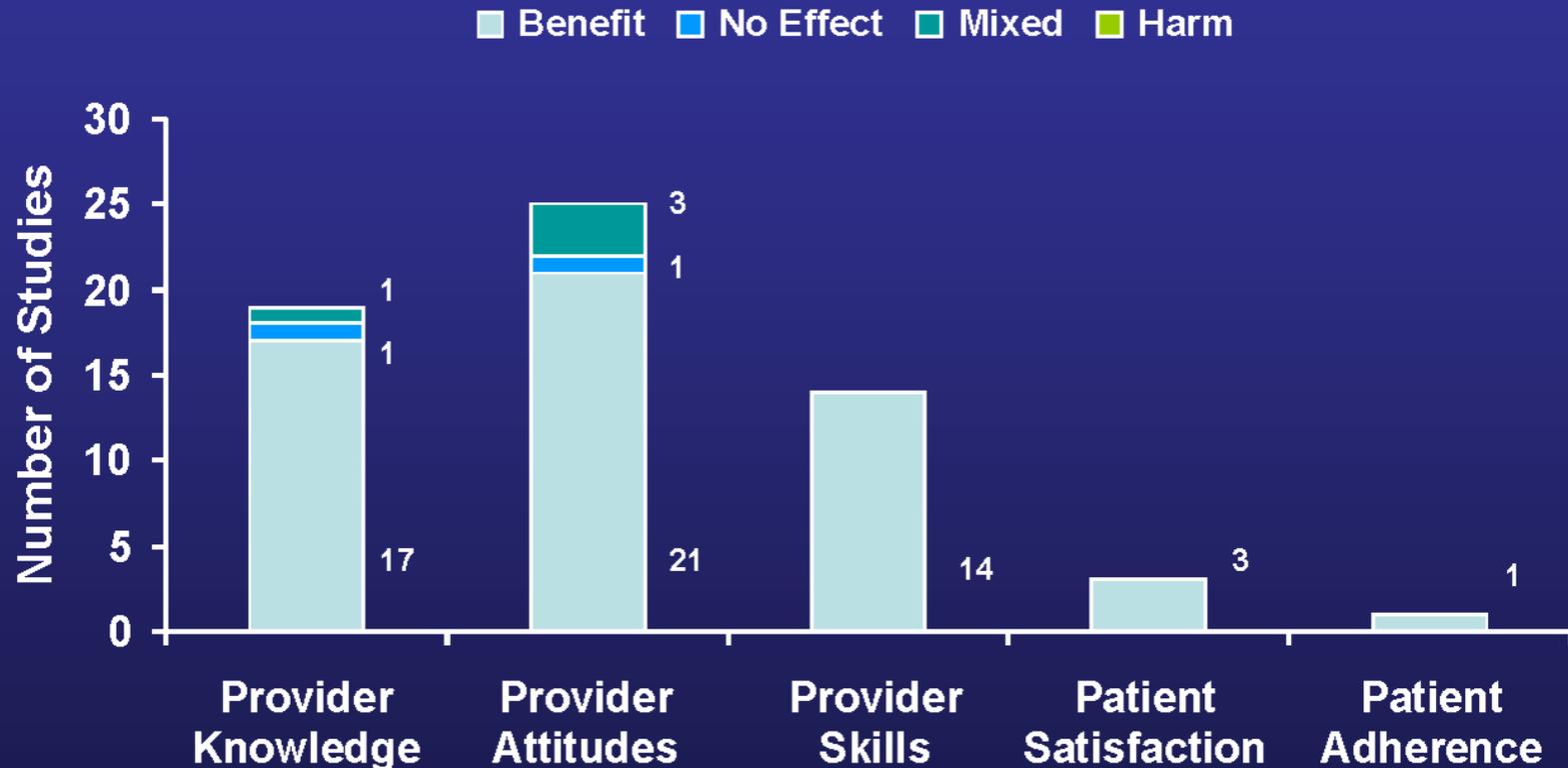
- Identify natural synergies and allies; consider competing interests

Evaluation to Date

Evaluation to Date

- ◆ Increase in knowledge regarding (Rubenstein et al):
 - How ignorance of a pt's health beliefs/practices can adversely affect the clinical encounter
 - Prevalence of “non-conventional” health beliefs/practices
 - Resources for learning about pt's health beliefs/practices
- ◆ Greater knowledge of (Nora et al):
 - Hispanic cult issues, including dis prev, health beliefs, practices
 - Anecdotal evidence (pre, post-test, OSCE's)

Cultural Competence Training Effects



^a34 studies: 2 randomized controlled trials, 12 controlled clinical trials, 20 pre-/postevaluation studies.

1. Beach MC et al. *Med Care*. 2005;43:356-373.

Challenges to Evaluation

- ◆ Difficult to measure attitudes
 - Social desirability bias; complexities of provider bias
- ◆ Standard “factual” evaluation of knowledge may not lend itself to cultural competence curricula and training
 - Culture fluid; certain components can be assessed
- ◆ Resistance to curricula and training
 - “soft science” lacking evidence base

Evaluation Strategies

◆ Attitudes

- Standard surveying (soc cog); structured interviewing
- Self-awareness assessments (role play and debrief)
- Presentation of cases, OSCE's, videotaped interaction

◆ Knowledge*

- Unknown clinical cases, MCQ's (pre, post test)
- Presentation of cases, OSCE's

◆ Skills

- Presentation of cases, OSCE's, videotaped interaction
- Structured interviewing

Linking Cultural Competence Training to Improved Health Outcomes

Linking to Outcomes

- ◆ Research has shown that the interventions that are successful in changing performance and health care outcomes are those that use:
 - Practice enabling strategies (e.g., office facilitators or methods of patient education)
 - Reinforcing methods (e.g., feedback or reminders)
 - Disseminating strategies
- ◆ Given this research, suggest that an educational intervention has the best chance of having an impact on health care outcomes if multifaceted and includes several key components
 - The “Culturally Competent Biosphere”

Linking to Outcomes

- ◆ Focus on one clinical condition
 - Would allow the use of a specific set of quality metrics for measurement, and that is the process that has been used to evaluate educational interventions in general.
- ◆ Target a particular population
 - Educational intervention might emphasize issues related to dealing with language barriers, understanding common conceptualizations of diabetes, etc.
- ◆ Teach specific skills
 - Standard cultural competence training that uses an agreed on set of principles and an effective teaching methodology should serve as the foundation for change
 - For the purposes of evaluation, a set of targeted, specific skills should be taught and measured

Linking to Outcomes

- ◆ Develop practice-enabling strategies
 - Decision-support tools (e.g., prompts in the electronic medical record for the clinician to ask specific questions), other reminders, and algorithms for handling common cross-cultural challenges
 - Instructional tool kits that highlight the key principles of cultural competence, pocket cards, and such support items that would facilitate the use of skills in the medical setting by the clinician
- ◆ Create a patient component
 - Provide the patient with a list of the key questions that the provider has been taught to ask, so that the patient can begin to give those questions consideration and feel more comfortable responding to them

Linking to Outcomes

◆ Key Measures

– Provider and Patient Satisfaction

- ◆ Assess satisfaction of both patient and physician with clinical encounter vis-a-vis cross-cultural components
- ◆ Survey questions should be linked to key skills being assessed and not be general questions that are not sensitive or specific enough to detect the impact of the educational intervention

– Process/Outcome

- ◆ If learners now following a cultural competence curriculum, patients are more frequently asked the explanatory model and, as a result, become more adherent to their medication regimens, then a positive effect may be detected.

Linking to Outcomes

◆ Key Measures

– Test ordering

◆ Can determine, through medical chart review, whether the use of particular cultural competence skills, such as the more frequent identification of a patient's explanatory model, provides greater benefits to the patient

– Patient undergoes additional appropriate testing (e.g., mammogram, pap smear, hemoccult tests, cholesterol screening)

– Avoids unnecessary tests (e.g., diagnostic imaging for back pain or headache) when they are not indicated

Linking to Outcomes

◆ Control for Confounders

- Any study that attempts to randomly assign clinicians to receive or not receive cross-cultural training and then compares patient outcomes must take into account patient panel characteristics (level of education, SES). For example:
 - ◆ A randomized controlled trial that focuses on training an intervention group to communicate more effectively with persons with asthma by measuring asthma-related emergency room visits and hospitalizations must take into account the environments in which these patients live
 - ◆ Even when asthmatic persons are taking the right medications, they can be adversely affected by their physical environment.

Summary

- ◆ Cultural Competence training gaining traction
- ◆ Evaluation should be held to same standard as for other educational interventions, in step-wise fashion
- ◆ As we strive to meet other challenges in American health care, so should we focus on developing the skills needed to care for diverse populations

Thank You

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