



CULTURAL COMPETENCY AND QUALITY OF CARE: OBTAINING THE PATIENT'S PERSPECTIVE

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ABSTRACT: Provision of “culturally competent” medical care is one of the strategies advocated for reducing or eliminating racial and ethnic health disparities. This report identifies five domains of culturally competent care that can best be assessed through patients’ perspectives: 1) patient-provider communication; 2) respect for patient preferences and shared decision-making; 3) experiences leading to trust or distrust; 4) experiences of discrimination; and 5) linguistic competency. The authors review the literature focusing on these domains, summarize the salient issues and current knowledge, and discuss the policy and research implications. Incorporating patients’ perspectives on culturally and linguistically appropriate services into current measures of quality will provide important data and create opportunities for providers and health plans to make improvements.

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EXECUTIVE SUMMARY

Noteworthy problems with access to health care and poor health outcomes among racial and ethnic minorities have been documented. Provision of “culturally competent” medical care is one of the strategies advocated for reducing or eliminating racial and ethnic health disparities. Cultural competence has been defined by the Office of Minority Health as “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.” This report examines culturally competent care from the patient’s perspective, explores methods for assessing culturally competent care, and identifies areas for further research. In particular, the authors sought to:

- develop a conceptual framework that identifies domains of culturally competent care from the patient’s perspective;
- review the literature focusing on these domains;
- summarize the salient issues and current knowledge; and
- discuss the policy and research implications.

Aspects of Culturally Competent Care from the Patient’s Perspective

Patient–provider communication. Patient–provider communication can be affected by such factors as differences in verbal and non-verbal communication styles and explanatory models of illness. Minority patients and individuals from lower socioeconomic backgrounds tend to receive less health-related information from their providers compared with non-minorities and individuals from higher socioeconomic backgrounds. Lack of patient–provider communication about the use of complementary and alternative medical practices is also a noteworthy problem.

- **Provider/health system recommendations:** The authors recommend that health care providers and health systems continually monitor their patient populations through quantitative and qualitative data collection methods. Specifically, data collection should include patients’ race or ethnicity, socioeconomic status, English language skills, and preferred language or language spoken at home. Intake forms should be modified to include questions that measure health literacy, English proficiency, language spoken at home, and use of complementary and alternative medical practices.

- Applied research recommendations: Research is needed to examine factors that influence patient–provider interactions among diverse racial/ethnic groups. Further research is needed to investigate the roles that patient navigators/coaches, community health workers, parish nurses, interpreters, and case managers can play in influencing patient–provider communication.

Shared decision-making and respect for patient preferences. Patient-centered care requires effective patient–provider partnerships, including shared decision-making among providers, patients, and families. Providers should work with patients to select treatments that take into account patients’ health-related values, weighing available treatment options and patient preferences. Current research shows that minority and low-income populations are more likely than white or higher-income patients to feel disenfranchised in the decision-making process and perceive a lack of respect for their preferences. In addition, studies have found that patients who make frequent use of complementary or alternative medicine often feel that providers do not respect their decision to use such therapies instead of (or in addition to) conventional medicine.

- Provider/health system recommendations: The authors recommend that providers investigate patients’ explanatory models of common diseases and their health-related values and preferences (e.g., why a patient thinks he has lung cancer and how he wants to involve his family in end-of-life decisions). At the systems level, policies should aim to democratize decision-making processes among patients, their families, and providers. Additionally, policies are needed to recognize patients’ rights to use alternative therapy or community-based programs in addition to conventional medical facilities.
- Applied research recommendations: Research is needed to investigate the association between patients and providers’ race/ethnicity and their treatment preferences. It is also important to examine what happens when patients and providers disagree on treatment options. More research is needed to determine how patients’ disclosure of their use of complementary or alternative medicine affects patient–provider interactions. Finally, research is needed to examine the use of lay health workers or other “cultural communicators” as facilitators. Cultural communicators observe the doctor–client interaction and help the health care provider and client understand each other.

Experiences leading to trust or distrust. Only a few studies have looked at the underlying causes of patient dissatisfaction and distrust of providers among racial and ethnic minorities. The existing studies consist mainly of small, qualitative investigations of

special populations. Current research indicates that minority patients who have race-concordant providers report higher levels of satisfaction with their care and lower levels of distrust.

- **Provider/health system recommendations:** It is important to evaluate the factors that affect patients' trust in their providers. Such factors may differ by racial/ethnic populations as well as socioeconomic and insurance status. Providers should seek to develop open channels of communication and empower patients to speak up about issues affecting their trust.
- **Applied research recommendations:** Further research is needed to understand why some patients prefer to be race concordant with their providers, and to gauge the effects of racial concordance on access to care, quality of care, and health outcomes. Research is also needed to explore and understand the root causes of distrust in providers, particularly among Latino and African American patients, for which studies conducted in different health care settings have yielded contradictory results. Finally, there is a need to explore whether differences in levels of trust of providers among racial and ethnic minorities, compared with whites, result from past experiences with the medical system or varying expectations.

Experiences of discrimination. Compared with white patients, racial and ethnic minorities perceive more instances of racism in the medical care system, tend to be less satisfied with their health care, and have higher levels of distrust in their health care providers. The reasons for these perceptions have not been definitively determined. Research on the role of racial bias or discrimination in the practice and delivery of health care is needed, as are valid measures for use in large-scale, population-based studies of the causes and health effects of perceived discrimination.

- **Provider/health system recommendations:** Providers need to be aware that racial and ethnic minority patients might perceive discrimination or bias in the health care system. Specific complaints of discrimination should be investigated and structural, system-wide changes and improvements should be sought. Patients should be given opportunities to voice their concerns about discrimination.
- **Applied research recommendations:** More research is needed to determine the placement of responsibility (e.g., on providers, staff, or others) for discrimination in health care settings and the characteristics (of patients or of the providers/staff members) that are most associated with incidents of bias. In addition,

understanding the consequences of perceived discrimination or bias on health is an important next step for future research.

Linguistic competence. Compared with English-speaking patients and those with higher levels of health literacy, limited English proficiency (LEP) patients and those with low health literacy are less likely to use health care services and adhere to medical regimens and more likely to have worse health outcomes. Linguistic competence includes communication strategies for LEP individuals and those with low health literacy. Language concordance between patients and providers is the most effective strategy to improve communication and health outcomes for LEP patients, though the use of professional interpreters can also be effective. Still, the majority of LEP patients lack access to trained interpreters. There are also effective techniques for communicating with patients with low health literacy.

- **Provider/health system recommendations:** The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA) should require hospitals and health plans to collect data on their patients' health literacy and English proficiency as part of the accreditation process. Insurers and policymakers should provide incentives for health care providers to improve services that specifically target patients who have low health literacy or limited English proficiency. Providers and health care systems should avoid the use of ad-hoc interpreters to communicate with LEP patients, and instead rely on trained bilingual staff and professional interpreters. Health plans and providers must monitor and assess the quality of interpreter services. Finally, medical schools and other health professional schools should incorporate issues pertaining to communication with patients who have low health literacy and/or LEP into their curricula. Medical schools should seek to increase recruitment and retention of bilingual students.
- **Applied research recommendations:** Further research is needed to assess the impact of various communication strategies for low health literacy patients, considering effects on health-related knowledge, compliance with care regimens, and health outcomes. More research on the mechanisms through which low health literacy and LEP may affect health outcomes is also needed. Finally, it is important to consider the implications for the health care system of patients who have both low health literacy and LEP.

Patient-provider communication, shared decision-making, and trust affect the quality of care of all patients, not just racial/ethnic minorities or those with low

socioeconomic status. However, problems in these areas of patient-centered care disproportionately affect vulnerable populations. Incorporating patients' perspectives on culturally and linguistically appropriate services into current measures of quality will provide important data and create opportunities for providers and health plans to make improvements.

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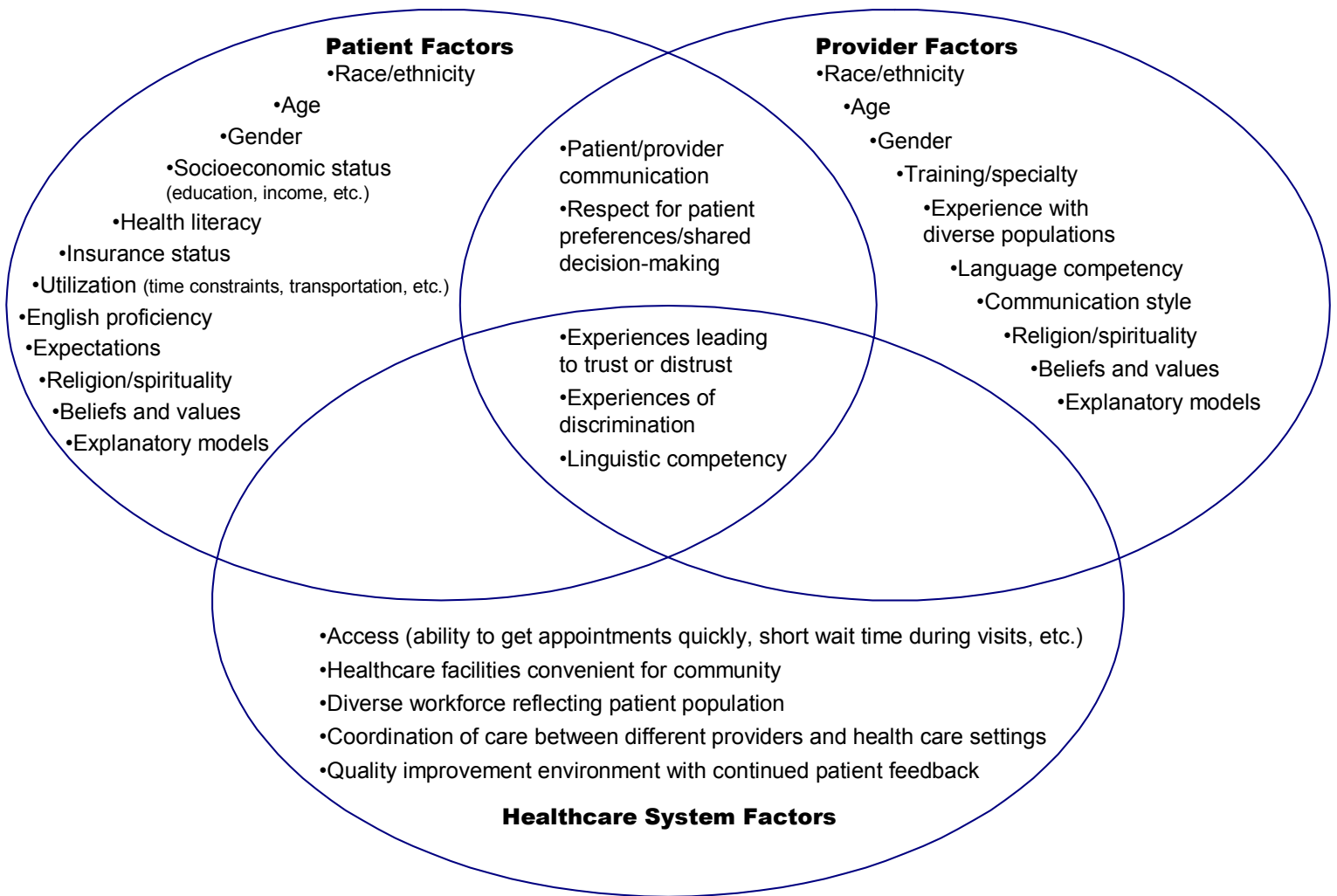
INTRODUCTION

Ample research has documented the existence of significant racial and ethnic disparities in access to health care, as well as poorer outcomes and health status among racial and ethnic minorities.¹ Various studies have looked at the causes of these disparities and recommended strategies for reducing or eliminating them. Among the strategies advocated is the provision of “culturally competent” medical care. The Office of Minority Health, using the definition developed by Cross and colleagues, has defined cultural and linguistic competence as “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.”² Although there has been much discussion in the medical, research, and public health communities about “culturally competent care,” little is known about how to accurately measure it.

In recent years, a “patient-centered” approach to the process and delivery of health care has been identified as crucial to providing culturally competent medical care. The Institute of Medicine defines patient-centered care as “care that is respectful of and responsive to individual patient preferences, needs, and values.”³ McWhinney described patient-centered care as being able to “see through the patient’s eyes.”⁴ Thus, one important way to measure the quality of culturally competent care is to obtain patients’ perspectives. Patients experience health care through their interactions with providers and other staff, and within the context of the health care systems such as health insurance plans and health care clinics. Patients’ previous experiences and unique characteristics will affect their views. For example, the perspective of care “through the patient’s eyes” may be different for an older African American woman from Haiti than for a young, white, non-Latino male.

This report examines culturally competent care from the patient’s perspective, explores methods for assessing culturally competent care, and identifies areas for further research. Figure 1 depicts a conceptual framework for obtaining patients’ perspectives on culturally competent care. The authors developed this framework based on the conceptual model of measuring health care quality among diverse populations developed by Bethell and colleagues.⁵ Many provider and system factors contribute to culturally competent care; this report focuses on the overlap between the three circles in Figure 1, which represents areas of care best measured through patient reports, rather than through provider reports or other sources.

Figure 1. Conceptual Framework of Culturally Competent Care from the Patient’s Perspective



The first two domains in these areas of overlap—patient–provider communication and respect for patient preferences/shared decision-making—include interactions between patients and providers: The other three domains—patient experiences leading to trust or distrust; experiences of discrimination; and linguistic competency—refer to patient–provider interactions, as well as patients’ interactions with other health care staff and the health care system overall.

Patients may be the best and perhaps the only source for these types of information. For example, one study found that Asian immigrants with limited English proficiency (LEP) reported experiencing discrimination from office staff, including interpreters, who “looked down” on them because of their limited English language abilities.⁶ This type of information would not have been revealed from interviews with

providers or health care administrators. Thus, the authors determined that these five domains of culturally competent care should be measured “through the patient’s eyes.” Other domains of care, such as access and coordination, are important aspects of quality of care in general. However, because these domains of quality have been extensively examined as part of “patient-centered” care, they are not examined in this report.

METHODOLOGY

Using the conceptual framework, the authors reviewed the literature addressing these five domains of care. The authors searched for articles published in English from January 1990 to September 2005, focusing on empirical studies conducted in the United States that included people of color (African Americans, Latinos, Asians and Pacific Islanders, and Native Americans).

ASPECTS OF CULTURALLY COMPETENT, PATIENT-CENTERED CARE

Patient–Provider Communication

Some racial/ethnic minority groups and those with lower socioeconomic status have a high probability of being uninsured, impeding their ability to seek and obtain health services.⁷ But even when access to care, diagnosis, and illness severity are the same, some minorities use health services that require a doctor’s referral at lower rates than whites. This suggests that barriers to care may emerge in the context of patient–provider interactions, rather than in accessing providers.⁸

Indeed, communication during medical interactions plays a central role in decisions about subsequent interventions, and can influence patient adherence, satisfaction with care, and health outcomes.⁹ One goal of the Cultural and Linguistic Access to Services (CLAS) standards on “Language Access Services,” as derived from the Healthy People 2010 goals, is to ensure the use of communication strategies to improve health.¹⁰ As defined in the Healthy People 2010 and CLAS documents, health communication is “the use of communication strategies to inform and influence individual and community decisions that enhance health.”¹¹ This includes efforts to assist patients in reaching their personal health goals. Better patient–provider communication increases awareness of health risks and risky behaviors, helps patients make choices by clarifying complicated issues, and increases the likelihood that patients understand and adhere to complex treatment regimens.¹² The negative impacts of ineffective patient–provider communication on health may be increased when cultural and linguistic barriers are also factors. Implementing the CLAS standards is expected to increase demand for appropriate health services and lower demand for inappropriate services.¹³

A Commonwealth Fund survey conducted in 2001 found that there was a positive association between physicians' cultural sensitivity and patient ratings of the quality of patient–physician interactions (including communication behaviors), regardless of the patient's racial/ethnic group.¹⁴ However, Asian Americans were less satisfied with care, more likely to report not being involved in decisions about their care, and less likely to report the doctor ever talking to them about lifestyle or mental health issues compared with white patients.¹⁵ Another study suggests that some physicians may be more verbally dominant, engage in less patient-centered communication, and exhibit lower levels of positive exchanges with African American patients than with white patients.¹⁶ The study did not explore the reasons for these differences, though racism may have played a factor.

Disparities in patient–provider communication. Some racial/ethnic groups and individuals of lower socioeconomic status are more likely than non-minority individuals and those of higher socioeconomic status to report poor communication with their physicians.¹⁷ Findings from the Commonwealth Fund's 2001 Health Care Quality Survey indicate that, while all demographic groups reported problems with patient–provider interactions, such difficulties were most pronounced for patients from racial/ethnic minority groups as well as populations with low education levels, low health literacy, and low incomes.¹⁸ Differences in communication styles and explanatory models of illness and disease can affect patient–provider communication.

Differences in communication styles. Patient–provider communication styles can be broadly grouped into verbal and non-verbal behaviors. As defined in the literature, “verbal” health communication includes providing directions, giving information, asking for clarification, showing concern, offering reassurance, talking socially, and establishing agreement. “Non-verbal” communications includes body language, including facial expressions and gestures designed to convey information and feelings such as happiness and distress.

Communication works in two directions. More expressive patients seem to fair better with Western providers than those that tend to be less expressive. Both verbal and non-verbal interactions can be affected by expressiveness, a trait that is influenced both by the patient's individual personality and his cultural background. Street et al. found that physicians' dispensing of information was influenced by patients' communication styles, such as whether they asked questions or were otherwise expressive.¹⁹ Research has also found that some physicians give more information to particular types of patients: for example, more educated patients receive more diagnostic and health information than their less-educated counterparts.²⁰

Strategies to encourage patients to express themselves have been shown to strengthen patient–provider communication. In a study of women with HIV/AIDS from various minority groups, patients involved in activities to encourage participation in decision-making about their care reported higher levels of communication with their providers and received more information and had more positive interactions than those who were not involved in such activities.²¹ In another study, Krupat and colleagues showed that assertive behavior among black patients and those with low socioeconomic status—but not among whites or those with low socioeconomic status—resulted in a greater likelihood that physicians would order full tumor staging for women seeking care for breast cancer.²²

Examining the issue of communications from patients’ perspectives can yield insights into how different groups value the different aspects of medical interactions. African American, Latino, and Asian patients rated providers’ displays of “concern, courtesy, and respect” as the most important factor in the health interactions.²³ Physicians’ non-verbal and interpersonal communication behaviors related to empathy and establishing rapport were found to be more important to minority patients compared with white patients than the verbal transmission of health-related information.²⁴ In separate studies based on the Commonwealth Fund 2001 Health Care Quality Survey, both Ngo-Metzger and Saha found that listening and spending adequate time were especially important aspects of health interactions for Asian and Latino patients.²⁵ In another study, Latinos were more likely than other racial groups to mention accessibility and availability as being important, while Asians and Pacific Islanders were more likely to mention that physicians ordering tests and giving appropriate referrals was important.²⁶ In contrast, African Americans cited participating in decision-making and building a trusting relationship with providers as the most important aspects of provider–patient interactions.²⁷

Discrepancies between patient and provider explanatory models of illness and disease. Patient–provider communication involves the use of meaningful language and gestures by providers to elicit a patient’s explanatory model of illness and arrive at a common understanding.²⁸ This approach to the construction of the meaning of health problems and concerns has been labeled the “explanatory model” by Kleinman and defined as “notions about episodes of sickness and its treatment that are employed by all those engaged in the clinical process.”²⁹ From a Western medical perspective, disease is the objective, measurable pathophysiology that creates the illness, which is the meaning of the disease to the individual and his or her social group.³⁰

Discrepancies between a patient's and a provider's explanatory models of illness and disease can lead to miscommunication. People who become ill, after self-treatment and home remedies, make choices about what to do next (e.g., whether to consult popular, folk, or professional sectors for additional assistance) based on their own assessment of their health needs. Individuals may choose to seek advice or treatment from relatives (e.g., for routine or familiar conditions), sacred folk healers (e.g., for spiritual or moral matters in which their expertise is required), and/or physicians or nurses (e.g., for serious biomedical conditions). People may act on one or more of these choices. For example, a state of illness perceived as divine retribution for a dishonest act may be treated with prayer and repentance alone, or may be treated with prayer together with medication prescribed by a physician.

Physicians, patients, and their families have explanatory models to guide them in making choices about illnesses and treatments and give personal and social meaning to their health experiences. Most providers trained in Western biomedicine belong to a biomedical culture in which diseases are natural, mechanistic errors, correctable by repairing organs or manipulating chemical pathways.³¹ In Western biomedicine, "disease" has no spiritual or metaphysical causes, though some diseases (such as sexually transmitted diseases) may have moral undertones related to risky behaviors. In contrast, patients from non-Western or indigenous cultures may understand their illnesses differently, and the separation of mind, body, and spirit characteristic of Western biomedicine may be difficult for such patients to accept.³² For some patients, the meaning of illness may include natural explanations (such as a fall that breaks a bone), supernatural (God's will or malevolent spirits), or metaphysical (such as bad airs or seasonal changes).³³ Miscommunication may occur when providers view the biomedical view of disease as the "right way" and discount the patient's perspective on his or her illness. When a provider and patient understand each other's explanatory models of disease and illness, negotiations for shared decision-making can take place in an atmosphere of mutual respect rather than frustration and misunderstanding.³⁴

Lack of communication about complementary and alternative medical practices.

Complementary and alternative medicine (CAM) refers to diverse practices and products that are not currently considered part of conventional medicine.³⁵ The use of CAM has increased in the last two decades. It is estimated that a racially and ethnically diverse group of 36 to 42 percent of the U.S. population used CAM in 2003, representing about \$27 billion in out-of-pocket spending.³⁶ An estimated 26 percent of African Americans, 28 percent of Hispanics, 36 percent of non-Hispanic whites, and 43 percent of Asian Americans use CAM.³⁷

The prevalence of CAM use among different racial/ethnic groups varies depending on the definition used.³⁸ For example, if the definition is expanded to include prayers for one's own health and megavitamins (high-dose vitamins), then approximately 60 percent of whites, Asians, and Latinos and 71 percent of African Americans use CAM.³⁹

Despite a steady increase in use of alternative therapies, there has been little change in the rate of patients' disclosure of CAM usage to their providers.⁴⁰ It is important for patients to discuss their use of CAM with their medical practitioners. Some therapies, such as herbal or vitamin therapies, may cause adverse events or interfere with medical regimens. Furthermore, knowledge of patients' CAM practices can provide valuable insight into patients' values, lifestyles, and health beliefs, which may, in turn, assist practitioners in providing optimum care.⁴¹ Yet, in a national survey of U.S. adults, 70 percent of patients who used CAM reported that their providers did not discuss CAM use with them.⁴²

Communication and patient-centered care. Effective patient-provider communication is crucial to the health outcomes of patients, yet some demographic groups disproportionately experience communication breakdowns. These problems may be partially explained by differences in communication styles, explanatory models of illness, and views of conventional Western medicine versus CAM.⁴³ However, little is known about the types of interventions that can help to bridge these communication gaps and improve patient-provider interactions.

Relationships between providers and patients are central to patient-centered care, which is based on partnerships among clinicians, patients, and their families and takes into account patients' needs and preferences.⁴⁴ This is furthered when patients receive information that is easy to understand, when providers are aware of potential communication challenges, and when care is provided with respect for patients' explanatory models, social environment, family context, and cultural beliefs and practices.⁴⁵

Shared Decision-Making and Respect for Patient Preferences

The Institute of Medicine encourages providers to respect patients' preferences and promote their active participation in clinical decision-making to the extent that patients feel comfortable and are willing to take part. Patients may participate in their care in a variety of ways, including having meaningful discussions about their preferences, knowing all of the available options, and making final decisions about treatment. Patients who are active participants in their care have been shown to have improved health outcomes, including lower levels of blood pressure and blood glucose.⁴⁶

Many people of color and those with lower socioeconomic status report problems with shared decision-making and respect for their preferences.⁴⁷ These individuals are more likely than white patients and those of higher socioeconomic status to perceive a lack of mutual trust and respect between them and their providers.⁴⁸ Lack of mutual trust and respect may limit clinicians' ability to provide care and patients' willingness to follow clinicians' advice. This can lower the quality of care and lead to increased morbidity and mortality. Ideally, in shared decision-making, a provider helps a patient translate their values into treatment decisions. Patients and providers collaboratively rank health-related values as they pertain to the decisions at hand, weighing available treatments against patient preferences.

A recent report by the Agency for Healthcare Research and Quality found that “blacks, Asians, Hispanics, and low income populations are more likely to feel disenfranchised in the decision-making process.”⁴⁹ In a national survey, nearly one of four people reported that they were not as involved in health care decisions as they would like. Compared with whites, African Americans and Asians more frequently reported under-involvement in the health care decision-making process (e.g., 22% of whites, versus 27% of African Americans and 42% of Asians reported that they were “not as involved as they would like to have been”). Similarly, Latinos were more likely than non-Latino whites to report feeling disenfranchised (34% vs. 21%), and low-income populations were more likely than higher-income populations to report this (30% vs. 20%).⁵⁰ In another study, more African American patients reported that their visits with physicians were less participatory than did whites.⁵¹

Roter et al. used audiotape analysis of 537 interactions to explore the relationships between primary care doctors and their patients.⁵² A key finding of the study was that African American and low-income patients were approached by their physicians in a narrowly biomedical pattern of communication (e.g., one that precluded psychosocial discussions and shared decision-making), compared with other patient groups. The reasons for this are unclear, although provider bias and stereotyping may be part of the explanation.⁵³

Shared decision-making and CAM use. An important component of respect for patient preferences is respect for their explanatory models of illness. As mentioned previously, many patients choose to use CAM in addition to conventional Western medicine. In a study among cancer patients, 35 percent of patients' attempts to initiate discussions about CAM were ignored by their providers.⁵⁴ In another study that included Latino patients, providers asked questions about the use of alternative therapies during only 3 percent of discussions.⁵⁵ To many patients, this lack of communication signified

disinterest on the part of their providers. Patients also worried that their providers may be unsupportive of CAM use, or try to persuade them not to use CAM.⁵⁶ Some patients feared that their providers might emphasize the need for scientific evidence. Or, when attempting to discuss CAM with their providers, patients feared they would become overwhelmed by the statistics and data demanded by the provider.⁵⁷

As discussed above, effective communication about CAM use is especially crucial for patients who take herbs or vitamins that can interact with prescription medications.⁵⁸ Patients are more likely to discuss CAM with their providers if they are confident that their preferences will be respected. Showing respect for patient's preferences should lead to a more effective relationship and potentially better health outcomes.⁵⁹ However, this assumption has not been tested and is an important area of future research.

Experiences Leading to Trust or Distrust

Patients who perceive positive characteristics in their providers (such as being thorough, understanding, responsive, and respectful) are more likely to seek treatment and heed medical advice.⁶⁰ Patients with higher levels of trust report improved satisfaction in the patient-provider relationship and patients with lower levels of trust report lower levels of satisfaction.⁶¹ A study by Thom et al. found that patients with low levels of trust in their providers were substantially less likely than those with higher levels to report that they intended to adhere to their physician's advice, and more likely to say they did not receive the services they requested or needed.⁶² When providers deny patients' requests for tests or treatment, patients' trust in their physicians may be eroded.⁶³ Bell et al. found that patients who felt their expectations for care had not been met reported less satisfaction with their visits, less improvement in their health conditions, and weaker intentions to adhere to treatment, compared with patients who felt their expectations had been met.⁶⁴ Collaboration and satisfaction in patient-provider relationships are associated with patients' participation in their care, fewer appointment cancellations and no-shows, and improved outcomes.⁶⁵

Racial and ethnic differences in patient trust. Several recent studies found low levels of patient trust and satisfaction among racial and ethnic minorities.⁶⁶ In a study of the foundations of mistrust in physicians, Schnittker found that people of lower socioeconomic status and members of racial and ethnic minorities said their physicians were less responsive and they were less trusting of their physicians compared with those of higher socioeconomic status and non-minority patients. In a study by LaVeist et al., both African American and white patients reported substantial mistrust of the medical system, yet African Americans were significantly more likely than white patients to report mistrust

across all measures. In this study, African American patients were more likely than whites to report racial discrimination as playing a factor in access to care. Those who perceived more racism and felt more mistrust of the medical system reported less satisfaction with care.

Using data from a nationally representative sample of adults, Hunt et al. found that the restrictiveness of an individual's health plan did not explain why some minority groups were less satisfied with their care.⁶⁷ African Americans and Latinos were less trusting and less satisfied with their physicians than whites regardless of their health plan characteristics. Other studies have found that Latinos and African Americans were less satisfied than whites were with their care and health plans. Weech-Maldonado et al. also found that Asians and Pacific Islanders had lower levels of satisfaction with their care and health plans than did whites.⁶⁸ In a study looking at patients' preferences for initial care by specialists, Wong et al. found that blacks and Asian patients had the least trust and the lowest ratings of specialists and were much less likely to prefer a specialist than were whites.⁶⁹

Only a few studies have looked at the underlying causes of patient dissatisfaction and mistrust, particularly among racial and ethnic minorities.

Organizational factors that affect patient trust. Some studies consider how the organization and delivery of medical care affect patient-provider relationships and patient trust and satisfaction. One study found a significant decline in the quality of patient-physician interactions between 1998 and 2000, as reported by Medicare beneficiaries.⁷⁰ Respondents reported "less thorough discussions about their problems and symptoms, greater difficulty reaching their doctor by phone for medical advice and in seeing the doctor when sick, and interpersonal treatment that felt less caring and more rushed." A study of low-income, mostly African American women demonstrated that primary care offices that were accessible (e.g., through long hours, short waiting times for appointments, easy telephone contacts, and ample time for individual appointments) and offered continuous and coordinated care (by assigning patients to the same clinicians and helping to coordinate specialty services) were associated with strong patient-provider relationships. Respondents who described their delivery sites as accessible and as ones that offered continuous and coordinated care were more likely than those who did not to say they had high levels of trust in their physicians.⁷¹

Hsu et al. found that patients who were allowed to select their primary care providers (PCPs) were more likely to retain their providers after one year and reported greater overall satisfaction with them, compared with patients who did not have such a

choice.⁷² In addition, patients who were allowed to choose their providers were more likely than those who were not allowed to do so to: follow their providers' advice, say their provider offered the best medical care, believe their provider thought the same way as they did, and believe their provider was well qualified and knew them well. Such patients also reported that their PCP created less of a barrier to obtaining care with specialists or prescription medications.

Hunt et al. found evidence that enrollment in a tightly managed health maintenance organization (HMO) was significantly associated with patients' reporting lower levels of trust in their physicians, compared with enrollment in a preferred provider organization (PPO).⁷³ The researchers also found that enrollment in a capitated HMO plan was significantly associated with lower levels of patient satisfaction, compared with a PPO plan. These findings are important, because racial and ethnic minorities are more likely than whites to be enrolled in restrictive, tightly managed health care plans.⁷⁴

Patient trust and health care utilization. The literature exploring the causes of patient mistrust among racial and ethnic minorities includes primarily small, qualitative studies of special populations. Nevertheless, these studies provide some insight into the factors that increase or decrease patient trust among racial and ethnic minorities, and the effects of trust on patient satisfaction and health care utilization.⁷⁵ A study of low-income, mostly minority, prenatal and postpartum women found that patient trust is closely associated with a provider's behaviors. This study found that patients' perceptions of a provider's competence were closely associated with their interpersonal skills and expressions of caring.⁷⁶ Three qualitative studies of battered, minority women point to the importance of providers' interpersonal skills in promoting positive relationships with their patients, and to the role of trust in encouraging women to seek help to address their partners' violence.⁷⁷ In particular, study participants identified provider behaviors such as compassion, understanding, accessibility, confidentiality, shared decision-making, and communication as adding to patient trust in providers and encouraging them to seek help for abuse.

Patient preferences, racial concordance, and trust. Studies show that racial and ethnic disparities in care can be partially explained by minority patients' preferences for care. Some studies found that African Americans are less likely than white patients to prefer certain treatments such as renal transplantation or invasive cardiac procedures.⁷⁸ In a study of patients' preferences for initial care, Wong et al. found that African Americans and Asians were less likely than whites to prefer initial care by a specialist in both hypothetical situations (i.e., when presented with a hypothetical scenario) and when asked about actual health problems. In addition, patients who were older and had more confidence in their

PCPs were less likely than younger patients or those with less confidence in their PCPs to prefer initial treatment by specialists.⁷⁹

In a study of doctor–patient racial concordance, Laveist and Nuru-Jeter found that respondents from various racial/ethnic groups, when given a choice among physicians, were more likely to select a physician of their own race or ethnicity than to select a physician of a different race/ethnicity.⁸⁰ Respondents who had physicians of the same race/ethnicity reported greater satisfaction with their physicians compared with respondents who were not race concordant with their physicians. This was true across racial and ethnic groups. The study did investigate why patients tend to choose a physician of their own race/ethnicity or whether racial concordance was associated with higher levels of patient trust.

In a study of racial concordance between HIV–positive patients and their providers, King et al. found that African American patients of white providers received protease inhibitors much later than did white patients of white providers or African American patients of African American providers.⁸¹ This study did not provide sufficient information to explain this difference. While it is possible that varying treatment times were the result of provider discrimination, it is also possible that lower levels of trust and satisfaction among African American patients in racially discordant patient–physician relationships influenced their willingness to try new therapies. Further research is needed to understand why patients prefer providers of the same race or ethnicity and to explore the effects of such racial concordance on access to care, quality of care, and health outcomes.

In addition, further research is needed to explore the root causes of Asian, Latino, and African American patients' mistrust of physicians. In addition, research is needed to better understand the degree to which patient mistrust is provider-driven (e.g., through discrimination or bias), structural (e.g., due to the organization and delivery of health care), or patient-driven (e.g. due to patient expectations and health beliefs). Furthermore, research is needed to explore whether differences in levels of trust among racial and ethnic minorities, compared with whites, could result from inadequate measures (e.g., poor translations or measures that are not culturally appropriate). Future studies should evaluate existing measures of patient trust and should be conducted in languages other than English and should explore the associations among age, education, socioeconomic status, acculturation, and patient trust among racial and ethnic minorities. A better understanding of the root causes of patient mistrust is crucial to developing strategies to increase trust and thereby improve health outcomes.

Experiences of Discrimination

While research uncovers inequalities in terms of access to and availability of health services as well as care among racial and ethnic minorities, compared with white patients, the reasons for these inequalities have not been definitively determined. For example, there is a large body of literature documenting racial differences in the treatment of cardiovascular disease.⁸² Other studies have found racial differences in rates of lung cancer surgery and immunizations.⁸³ In addition, greater morbidity and mortality from HIV have been observed among African American patients than whites.⁸⁴ Some studies have found that racial and ethnic minorities perceive more racism in the medical care system and tend to be less satisfied with their health care and their health care providers than white patients.⁸⁵ As described above, patients' attitudes toward health providers and health care institutions affect their willingness to seek medical care, undergo treatments, and adhere to recommended care.⁸⁶

While some studies have speculated that racial bias or discrimination in the practice and delivery of health care is at least partly responsible for racial and ethnic health disparities, more research on this issue is needed.^{87,88,89} In particular, further research is needed to improve our understanding of the consequences of discrimination (or perceived discrimination) for patients' health. Some studies have found that perceived discrimination is associated with negative health outcomes, in addition to lower health care satisfaction and treatment adherence. For example, Thornburn et al. found that many HIV-positive patients have experienced discrimination in getting treatment for HIV, and that such racially and socioeconomically based discrimination was associated with higher rates of depression and post-traumatic stress symptoms, greater severity of AIDS-related symptoms, and lower perceived general health.⁹⁰ However, too few studies have looked at this issue, and existing studies are limited by small sample sizes, cross-sectional designs, and the use of discrimination measures that have not been adequately evaluated.

To explore the health effects of perceived discrimination, studies need reliable and valid measures that can be feasibly used in large-scale, population-based studies. Krieger et al. set out to fill this gap by investigating the psychometric properties of a short self-report instrument called the "Experiences of Discrimination" (EOD) measure.⁹¹ In this study, the EOD was tested on a sample of black, Latino, and white adults in the Boston area. The results yielded evidence in favor of the reliability and validity of the nine-item EOD scale and showed that single-item discrimination measures were less reliable than, and had low correlations with, multi-item measures. These findings provide support for use of the EOD to assess perceived discrimination among African Americans and Latinos.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are designed to assess patients' health care experiences in a variety of settings.⁹² A six-item measure of perceived discrimination adapted from items used in the Commonwealth Fund 2001 Health Care Quality Survey was evaluated as part of a field test of the CAHPS American Indian survey conducted in 2005.⁹³ Analyses were conducted to examine survey response rates, items missing data, and the reliability and validity of the survey. The overall survey findings are encouraging in terms of the quality of the data collected, and psychometric analyses provided strong support for the reliability and validity of the survey, but the discrimination items did not coalesce into a homogenous scale (item-scale correlations tended to be low).⁹⁴

Linguistic Competence

The National Center for Cultural Competence defines linguistic competence as:

The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.⁹⁵

Racial and ethnic minorities are disproportionately affected by communication barriers associated with LEP and low health literacy.

Health literacy. Healthy People 2010 defines health literacy as the “degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.”⁹⁶ Health literacy is not limited to reading and writing; it also includes speaking and listening skills. As such, people with low health literacy tend to have problems with both written and oral communication.⁹⁷

According to the 1992 National Adult Literacy Survey, half of U.S. adults have limited or low literacy skills.⁹⁸ In a meta-analysis of studies on health literacy, Paasche-Orlow et al. found that the prevalence of low and marginal health literacy was 46 percent. Low health literacy was significantly associated with level of education, ethnicity, and age.⁹⁹

Individuals with low health literacy are less likely than those with adequate health literacy to understand their disease, possess skills to manage their own conditions, and use preventive health care services.¹⁰⁰ In addition, individuals with low health literacy have lower rates of adherence to recommended treatments, are more prone to experience medication errors, and are more likely to have poorer health status and worse health outcomes.¹⁰¹

The mechanisms by which poor health literacy affects health outcomes are not clear.¹⁰² However, it is likely that poor patient–provider communication may be a mediating factor. Research has generally found that individuals with low health literacy have more difficulties understanding health information.¹⁰³ Schillinger et al. found that, compared with diabetic patients with adequate health literacy, diabetic patients with low health literacy were more likely to report worse communication in the domains of general clarity, explanation of conditions, and explanation of processes of care.¹⁰⁴ Communication barriers can affect all aspects of health care encounters, from history-taking to explaining diagnoses and treatments.

Physicians’ use of medical terms and the speed with which they transmit information may cause communication problems. Such problems may be exacerbated by the fact that patients with low health literacy tend to have passive communication styles.¹⁰⁵ Patients with low health literacy may be hesitant to disclose their problems to their providers or unwilling to admit they do not understand their physicians. Furthermore, they may lack the vocabulary to phrase their questions.¹⁰⁶ Communication barriers may arise when individuals with low health literacy attempt to understand medical forms and instructions, which are usually written at high school reading level or higher.¹⁰⁷ This includes informed consent and insurance forms, prescription labels, and medication package inserts.

Such communication problems may be exacerbated by the current health care environment, in which physicians have little time for providing information or explanations. Indeed, the American Medical Association concluded that “physicians are not successful in communicating essential health care information to their patients, particularly to those with inadequate health literacy.”¹⁰⁸ Often, providers are unaware of the communication needs of their patients and do not tailor their communication styles to fit patients’ needs.¹⁰⁹ Providers should be encouraged to look for clues of limited literacy skills. For example, patients may make excuses to avoid reading something (e.g., they have forgotten their reading glasses or will read it when they get home), fill out forms incompletely or inaccurately, or bring family members along to office visits.¹¹⁰

Although educational level can be a marker for low literacy, it is not strongly correlated with literacy skills.¹¹¹ Therefore, it is recommended that providers formally assess the health literacy of their patients. Common instruments to assess literacy levels include the Rapid Estimate of Adult Literacy in Medicine, the Test of Functional Health Literacy in Adults (TOFHLA), a shortened version of TOFHLA, and the Wide Range Achievement Test (WRAT).¹¹² The only health literacy measure for Spanish-speaking

patients that has been evaluated psychometrically is the TOFHLA, and further research is needed to evaluate the performance of the shortened version of TOFHLA among Spanish speakers.¹¹³ Research is also needed to evaluate these health literacy assessments among other non-English speakers, especially Asians.

Several strategies have been suggested as ways for providers to improve their oral and written communication with patients who have low health literacy, as follows:¹¹⁴

- Reduce the content of discussions to what patients really needs to know; for example, discussing how to manage a chronic disease as opposed to the disease's pathophysiology.
- Avoid use of medical jargon and instead, use commonly understood words.
- Use audiovisual aids to supplement oral and written instructions, such as diagrams and pictures or short audio or videotaped instructions.
- Include interactive instructions by making patients do, write, say, or show something to demonstrate their understanding. For example, ask patients to “teach back” by repeating or restating the instructions as the patient might tell a friend.
- Test the readability of educational materials. Write materials at a sixth-grade reading level or lower.
- Pretest materials to evaluate whether they are suitable for the intended audience.

Most studies examining the effectiveness of such communication strategies have focused on their impact on patients' knowledge, health behavior, biochemical markers, measures of disease incidence, and use of preventive services.¹¹⁵ To date there have been no studies examining the impact of communication strategies on health care service use or health outcomes. The authors' literature review found only five studies that used a controlled research design to assess the impact of communication strategies by literacy level, and these were limited to studying knowledge outcomes. For example, Michielutte et al. compared the effects on patients' knowledge of an illustrated brochure on cervical cancer and a brochure using bulleted text only. The study found that patients with low health literacy scores understood the illustrated materials better than the text-only version.¹¹⁶

Limited English proficiency. According to the 2000 census, approximately 47 million people in the U.S. speak a language other than English at home and over 21 million are limited English proficient (LEP)—the term used by the U.S. Department of Health and

Human Services Office of Civil Rights to refer to people that have poor or no English skills.¹¹⁷ Previous research has shown that LEP patients have worse access to care and give poorer ratings of their care than English-speaking patients.¹¹⁸ Strategies used to surmount language barriers include: bilingual providers who are proficient in the patient's language (often referred to as language-concordant encounters); in-person, third-party interpretation, using dedicated, trained professional interpreters or ad-hoc interpreters, such as patient's family members, friends, or clinic staff; and remote, third-party interpretation using technology.¹¹⁹

A nationally representative survey in 2001 found that only 49 percent of Hispanic adults who said they needed medical interpretation always or usually got an interpreter.¹²⁰ Of those who used an interpreter, 55 percent of patients worked with an ad-hoc staff interpreter, 43 percent relied on a family member or friend, and only 1 percent had a trained, dedicated medical interpreter. A 2003 survey in California found that, among non-English-speaking patients who did not have a doctor who spoke their native language, most (56%) did not rely on interpreters but rather did "the best they can in English."¹²¹ Only 9 percent had professional interpreters, while 15 percent used ad-hoc interpreters and 19 percent depended on family members or friends for translation.

Language-concordant encounters. Language-concordant encounters result in better communication, interpersonal processes, and health outcomes than language-discordant encounters. Bilingual providers who can speak directly to their patients may develop better rapport with them.¹²² Seijo et al. found that Spanish-speaking patients who saw bilingual physicians asked more questions and had greater information recall of their physician's diagnosis, treatment, and recommendations than Spanish-speaking patients who saw a monolingual (English-speaking) physician.¹²³ Wilson et al. found that, among a multilingual population, LEP patients with language-discordant physicians were more likely to report problems understanding a medical situation than LEP patients with language-concordant physicians.¹²⁴ Finally, Perez-Stable et al. found that patients with diabetes and hypertension reported better health outcomes when their physician spoke their native language.¹²⁵ One limitation of these studies was that, when considering language-discordant encounters, they did not differentiate between interpreted and non-interpreted encounters.

Studies comparing language-concordant encounters with interpreted encounters have shown that patients in language-concordant encounters have better experiences with care. For example, studies indicate that language-concordant encounters can result in patients having a better understanding of their condition.¹²⁶ Compared with language-

concordant encounters, patients communicating through an interpreter rated their providers as less friendly, less respectful, less concerned for them as a person, and less likely to make them feel comfortable.¹²⁷ These studies did not distinguish between the types of interpreter services available.

Interpreter services. The limited supply of bilingual providers has led health care organizations to use interpreter services to bridge language gaps. Research has shown that language-discordant patients report better experiences with care in interpreted encounters than in non-interpreted encounters. Work by Baker et al. found that interpreter use among Spanish-speaking patients led to greater understanding of their disease and treatment.¹²⁸ Spanish-speaking patients who communicated directly with their providers but thought an interpreter should have been called were less satisfied with their provider's friendliness, concern, efforts to make them feel comfortable, and the amount of time spent with them, compared with patients who had language-concordant encounters and those who used an interpreter.¹²⁷

When examining the impact of language services, it is important to distinguish between professional interpreters and ad-hoc interpreters. Availability of professional interpreters may reduce barriers to care among LEP patients. Jacobs et al. found that professional interpreter services offered by a managed care organization increased the use of clinical and preventive services among Portuguese- and Spanish-speaking patients.¹²⁹ Tocher and Larson reported that the quality of care for diabetic LEP patients was as good, if not better, than for their English-speaking counterparts when professional interpreter services were available.¹³⁰ The availability of staff interpreters has been shown to improve compliance with follow-up appointments and overall satisfaction.¹³¹

Several studies have found communication problems with the use of ad-hoc interpreters. Although such interpreters are bilingual, they are not formally trained as interpreters and may lack appropriate knowledge of health-related terminology. As a result, patients may receive insufficient information about potential side effects and be less satisfied generally with their care.¹³² Elderkin-Thompson et al. reported that translation errors occurred frequently when untrained nurse interpreters were used—approximately half of the encounters observed had serious miscommunication problems that affected the physician's understanding of the patient's symptoms and concerns.¹³³ Flores et al. found that, compared with errors committed by professional interpreters, errors committed by ad-hoc interpreters were more likely to be errors of clinical significance.¹³⁴ Finally, several studies in a variety of different settings found significantly higher quality of patient-

physician interactions when professional interpreters were used instead of ad-hoc medical staff or patients' friends or family members.¹³⁵

In addition to the potential for the problems discussed above, use of family members or friends as translators may result in them filtering information to reduce emotional distress for the patients.¹³⁶ Furthermore, relaying medical information can be burdensome on family members or friends—particularly children—and may lead to patient dependency and passivity.¹³⁷ There may be certain advantages to using adult family members as interpreters, including their ability to offer support, help remember details, encourage adherence to treatment, and increase knowledge in the family.¹³⁸ Some studies have found similar levels of patient satisfaction with professional and family member/friend translators, while other studies indicate that patients prefer professional interpreters.¹³⁹

Professional interpreter services may be in-person or remote. Remote interpreter services rely on telephones, video links, or other systems. Some remote interpreter services offer simultaneous interpretation through wireless headsets, based on the model in use at the United Nations. One limitation of remote systems is that the interpreter cannot capture non-verbal communication cues.¹⁴⁰ Studies contrasting in-person and remote interpreter services have had mixed results. Kuo and Fagan found that patients using professional in-person interpreters were more satisfied than those using telephone interpreters.¹⁴¹ On the other hand, Hornberger et al. found that remote-simultaneous interpretation was more accurate than in-person interpretation, and Spanish-speaking parents reported a significant preference for this interpretation style.¹⁴² One limitation of this study was that training was provided only to the remote-simultaneous interpreters and not to the in-person interpreters.

There is wide variation in the quality of interpreter services. Interpretation should include proficiency in both languages, mastery of medical terminology in both languages, memory skills, ability to negotiate a three-way conversation, and basic knowledge of cultural aspects that can influence health. Moreover, bilingual providers should be proficient in the target language, including knowledge of medical terminology.¹⁴³ There are currently no minimum requirements for medical interpreter training programs, but the National Council on Interpreting in Health Care recommends at least 40 hours of instruction on medical terminology, interpreting skills, ethical issues, role playing, and cultural awareness.¹⁴⁴

DISCUSSION

Our review of the literature demonstrates the importance of culturally competent, patient-centered care to patient satisfaction, adherence, and outcomes. From the patient's perspective, the patient-provider interaction is a key, if not the primary, component of quality medical care.

Yet, multiple studies in multiple settings have found that racial/ethnic minority patients as well as those with low socioeconomic status or LEP report worse experiences of care, compared with whites, those with higher socioeconomic status, and English speakers. The causes of these health disparities remain unclear: they may result from bias on the part of the providers, differences in patients' expectations, or miscommunication across biomedical or cultural divides.¹⁴⁵ Organizational factors—such as the lack of continuous care and pressure on providers to work quickly—may further erode the quality of patient-provider interactions. Indeed, research has suggested that the pressure on providers to make decisions in short periods of time may contribute to stereotyping of patients.¹⁴⁶

Given current knowledge, how can we improve the cultural competency of providers and organizations? Incorporating the patient's perspective into current quality improvement efforts is an important step. The authors have identified five domains of care that are best identified and measured “through the patient's eyes.”

Patient-provider communication can be affected by such factors as differences in verbal and non-verbal communication styles and explanatory models of illness and disease. Some disparities in use of provider services emerge after the patient gets to the provider (in the context of patient-provider interaction) rather than just difficulties in getting to the provider, demonstrating that patient-provider communication is not unidirectional: just as providers can influence patient behaviors, patients can influence provider behavior. For example, if clients consistently demonstrate an inability to understand provider instructions, the provider must make an effort to modify the means used to communicate these instructions, such as illustrations or the adoption of terms and phrases that are commonly used by that client's group.

In terms of *shared decision-making and respect for patient preferences*, the authors found that: 1) patient-centered care requires effective patient-provider partnerships and shared decision-making among clinicians, patients, and families; 2) providers should work with patients to select interventions that reflect patients' values, weighing available treatments with patient preferences; and 3) shared decision-making is influenced by the unique

characteristics of providers and patients, though there is a dearth in the understanding of how this plays out. Focused, formative research is needed to examine patient–provider relationships. Then, outcome–based interventions are needed to evaluate findings from the formative research process.

In terms of *experiences leading to trust or distrust*, the authors found that: 1) patients consider their provider’s interpersonal characteristics essential to competent care and take them into consideration when determining the quality of the care they receive; 2) shared decision–making between patients and providers is unlikely to occur without mutual trust; 3) patient participation in care is associated with greater collaboration and increased satisfaction on the part of patients; and 4) few studies have looked at the underlying causes of patient dissatisfaction and distrust among racial and ethnic minorities. Studies examining the factors that influence patient–provider relationships should be undertaken. In particular, evidenced–based studies are needed to gauge the extent to which trust influences patient–provider relationships.

In the fourth domain, *experiences of discrimination*, findings indicate that: 1) compared with white patients, racial and ethnic minorities perceive more racism in the medical care system, tend to be less satisfied with their health care, and have higher levels of distrust in their health care providers; 2) the inequalities in access and availability of care among racial and ethnic minorities have not been definitively explained; 3) further research on the role of racial bias or discrimination in the practice and delivery of health care is needed; and 4) reliable and valid measures that can be used in large–scale, population–based studies are needed to understand the causes and health effects of perceived discrimination.

For the fifth domain of care, *linguistic competency*, the authors examined communication strategies for individuals with LEP and low health literacy. They found that: 1) low health literacy is an important communication barrier, especially among racial/ethnic minorities; 2) low health literacy can have consequences for health care utilization, adherence to medical regimens, and ultimately health outcomes; 3) there are different strategies for providers to improve their oral and written communication with low health literacy patients; and 4) providers must be cognizant of their patients’ health literacy needs so they can adapt their communication styles.

With respect to LEP patients, the authors found that: 1) the majority of LEP patients in the U.S. still lack access to language services; 2) access to language services can help improve LEP patients’ experiences with and access to care; 3) language–concordant encounters result in better communication, interpersonal processes, and outcomes than

language-discordant encounters; and 4) language concordance between patients and providers, as well as interpreting by trained professionals, are the most effective strategies for communicating with LEP patients.

IMPLICATIONS

It is important for all sectors of the health care system to continuously monitor their own patient populations with regard to the five domains of culturally competent care. In addition, evaluations of cultural competency should be incorporated at all levels of care. This should include cultural competency training and assessment of all people who are the points of contact for clients, such as front-desk staff, providers, and others. Obtaining patients' perspective will provide thorough and in-depth knowledge of how to make improvements. It is also critical that providers seek to understand the community and socio-cultural environments that influence patients' beliefs about illness and disease, as well as the values that patients assign to various elements of the health system.

Recommendations for Providers and Health Systems

Patient-provider communication. The authors recommend that health care providers and health systems continually monitor their patient populations through quantitative and qualitative data collection methods. Specifically, data collection should include patients' race/ethnicity, socioeconomic status, and linguistic abilities. Intake forms should be modified to include questions regarding health literacy, English proficiency, language spoken at home, and use of complementary and alternative medical practices.

Shared decision-making and respect for patient preferences. Providers should work with patients to select treatments that take into account patients' health-related values, weighing available treatment options and patient preferences. To do so, they should adopt strategies to determine patients' explanatory models of common diseases. The health system should implement policies to democratize the decision-making process among patients, their families, and providers. Policies should also recognize the rights of health consumers to use community-based agencies and programs in addition to conventional medical facilities.

Experiences leading to trust or distrust. It is important to evaluate the factors that affect patients' trust in their providers. Such factors may differ by racial/ethnic populations as well as socioeconomic and insurance status. Providers should seek to create open channels of communication and empower patients to speak up about issues affecting their trust.

Experiences of discrimination. Providers must be aware that racial and ethnic minority patients might perceive discrimination or bias in the health care system. Specific

complaints of discrimination should be investigated and structural, system-wide changes and improvements should be sought. Patients should be given opportunities to voice their concerns about discrimination. Providers and health systems should use a modified version of the “Experiences of Discrimination” measure for quality improvement purposes.

Linguistic competence. Health plans and providers should assess the health literacy and language needs of their patient population, and adopt strategies that will improve their written and oral communication with patients. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA) should require hospitals and health plans to collect data on their patients’ health literacy and English proficiency as part of the accreditation process. Patient assessments of care such as the CAHPS surveys should include dimensions related to communication barriers for patients with low health literacy and limited English proficiency. Policymakers should make health literacy assessments available in languages other than English and Spanish.

Insurers and policymakers should offer incentives for health care providers to create services that improve care for patients with low health literacy and/or limited English proficiency. Providers and health care systems should avoid the use of ad-hoc interpreters to communicate with LEP patients, and instead rely on trained bilingual staff and professional interpreters. Health plans and providers must monitor and assess the quality of interpreter services.

Finally, medical schools and other health professional schools should incorporate issues pertaining to communication with patients who have low health literacy and/or limited English proficiency into their curricula. Medical schools should seek to increase recruitment and retention of bilingual students.

Recommendations for Applied Research

Patient–provider communication. Research is needed to examine factors that influence patient–provider interactions among diverse racial/ethnic groups. Further research is needed to investigate the roles that patient navigators/coaches, community health workers, parish nurses, interpreters, and case managers might play in influencing patient–provider communication.

Respect for patient preferences and shared decision-making. Research is needed to investigate the association between patients and providers’ race/ethnicity and their treatment preferences. It is also important to examine what happens when patients and providers disagree on treatment options. More research is needed to determine how

patients' disclosure of their use of complementary or alternative medicine affects patient-provider interactions. Finally, research is needed to examine the use of lay health workers or other "cultural communicators" as facilitators to enhance the shared decision-making process and improve the desired outcomes of the encounter.

Experiences leading to trust or distrust. Further research is needed to understand why some patients prefer to be race concordant with their providers, and to gauge the effects of racial concordance on access to care, quality of care, and health outcomes. Research is also needed to explore and understand the root causes of distrust in providers, particularly among Latino and African American patients, for which studies conducted in different health care settings have yielded contradictory results. Finally, there is a need to explore whether differences in levels of trust of providers among racial and ethnic minorities, compared with whites, result from past experiences with the medical system or varying expectations.

Experiences of discrimination. More research is needed to determine the placement of responsibility (e.g., on providers, staff, or others) for discrimination in health care settings and the characteristics of patients or providers/staff members associated with incidents of reported bias. In addition, understanding the consequences of perceived discrimination or bias on health is an important next step for future research. It should be possible to modify the "Experiences of Discrimination" measure to evaluate health encounters.

Linguistic competence. More research on the mechanisms through which low health literacy and limited English proficiency may affect health outcomes is needed. It is also important to consider the implications for the health care system of patients who have both low health literacy and limited English proficiency.

Further research is also needed to assess the impact of various communication strategies on low health literacy patients, considering effects on health-related knowledge, compliance with care regimens, and health outcomes. It is also important to examine the reliability and validity of health literacy assessments that have been translated into languages other than English.

For patients with limited English proficiency, it is important to evaluate various translation methods, for example considering the cost-effectiveness of remote versus in-person professional interpreter services or the appropriateness of using family members as interpreters.

Incorporating Patients' Perspectives of Cultural Competence into Quality Measures

To measure and improve care, it will be important to incorporate patients' perspectives of cultural competence into existing measures of health care quality. In October 2005, NCQA and *U.S. News & World Report* collaborated to rank hundreds of commercial, Medicare, and Medicaid health plans.¹⁴⁷ The NCQA is a private, nonprofit organization that accredits and certifies a range of health care organizations. NCQA's accreditation program is voluntary; participating health plans submit information about member satisfaction and clinical performance. Two of the five areas used to rank health plans were access to care and communication with doctors. "Access to care" takes into account patients' reports of their experiences with getting needed care, getting care quickly, and health plan customer service. "Communication with doctors" includes patients' perceptions on how well doctors communicate, as well as patient ratings of their personal doctor or nurse, the specialist seen most often, and the overall health care received. These areas were assessed using the CAHPS health plan survey version 3.0.

It would be possible to include additional survey questions to assess a health plan's cultural competency, at least from the patient's perspective. For example, the authors recommend that all health plans, including Medicare and Medicaid plans, routinely collect the following socio-demographic data from their members: 1) race and ethnicity; 2) education; 3) preferred language; 4) English-language proficiency; 5) health literacy level; and 6) acculturation level, or degree of assimilation to mainstream American culture. It would also be important to ask patients about the race/ethnicity of their personal doctor or nurse and the language spoken during most health encounters. For patients with limited English proficiency, additional questions could be asked about the language services available to them and about the quality of interpreter services. Furthermore, patients could be asked whether they share in the decision-making process with their providers, given the importance this holds for their adherence to recommended treatments. Given the widespread use of CAM among all population groups, including whites, it is also important to determine if providers are asking patients about their use of CAM. Additional questions about trust and discrimination would provide understanding about patients' experiences in these areas. Table 1 shows the cultural competency domains discussed in this report and indicates whether there are existing CAHPS survey questions to solicit patients' perspectives on these domains of care.

Table 1. Comparisons of Diverse Patients' Health Care Experiences and Quality of Care Domains Covered by the CAHPS Instruments*

Quality Domains	Diverse Patients' Health Care Experiences	CAHPS Questions
Patient–Provider Communication		
➤ How Well Providers Communicate	<ul style="list-style-type: none"> • Providers listen carefully. • Providers explain things in a way that is easy to understand. • Providers spend enough time. 	<p>YES YES YES</p>
➤ How Well Providers Understand and Respect Patients' Explanatory Models of Illness and Disease	<ul style="list-style-type: none"> • Providers discuss patients' health beliefs and practices in a non-judgmental manner. • Providers can communicate about non-conventional or complementary and alternative medical practices. • Providers find common ground between biomedical view of disease and patients' perspectives on their illness. 	<p>NO NO NO</p>
Respect for Patients Preferences/ Shared Decision-Making	<ul style="list-style-type: none"> • Providers and staff show respect and treat patients with dignity. • Providers and staff display empathy and show emotional support. • Providers discuss pros and cons of treatment options. • Providers allow patients and family to have a voice in treatment decision-making. 	<p>YES NO YES YES</p>
Experiences Leading to Patient Trust or Distrust in Health Care Systems and/or Providers	<ul style="list-style-type: none"> • Health Care staff treated patients in a way that led to distrust. • Providers treated patients in a way that led to distrust. • Patient had experiences with denial of services that led to distrust. • Patient had experiences with denial of payment that led to distrust. 	<p>NO NO NO NO</p>
Experiences of Discrimination	<ul style="list-style-type: none"> • Providers or staff treated patients with disrespect because of patients' racial/ethnic backgrounds. • Providers or staff treated patients with disrespect because of patients' insurance status. • Providers or staff treated patients with disrespect because of patients' ability to speak English. 	<p>NO NO NO</p>

Quality Domains	Diverse Patients' Health Care Experiences	CAHPS Questions
Linguistic Competence		
➤ Effective Communication for Individuals Who Have Low Health Literacy Skills	• Providers and staff use plain language and not medical jargon.	NO
	• Providers and staff provide written health-related information that is easy to understand.	YES
	• Providers and staff provide non-written patient education materials such as pictures, models, and videotapes.	NO
	• Providers and staff give patients small amount of information and repeat information until patients understand.	NO
	• Providers and staff make patients feel comfortable asking questions and allow time for questions.	NO
➤ Effective Communication for Individuals Who Have Limited English Proficiency	• Patients are able to make appointments using the language they are most comfortable with.	NO
	• Patients have access to professional, culturally appropriate interpreters at the time of visit.	NO
	• Interpreters are available at the appropriate time and spend enough time as needed.	NO
	• Gender-concordant interpreters are available for sensitive issues.	NO
	• Interpreters provide accurate and complete translations.	NO
	• Interpreters treat patients with courtesy and respect.	NO
	• Written and non-written health-related information is provided in the patients' native language.	NO

* Some CAHPS surveys may include questions that partially cover these domains. Domains that are not covered, or have limited coverage, have been designated as “NO.”

In collecting such data, it would be important for health plans to address any methodological issues inherent in the survey design and sampling process. Often, problems with data collection processes lead to under-representation of low-income, LEP, and low health literacy patients, resulting in a sample skewed toward populations with higher socioeconomic status—excluding patients who are most at risk.¹⁴⁸

Efforts such as the collaboration between the NCQA and *U.S. News and World Report* are important ways to give health consumers more information about health care quality. The authors recommend going a step further to include patient reports and ratings that will enable evaluations of the cultural and linguistic abilities of a health plan and its providers. Improving patient–provider communication, shared decision–making, and trust are quality issues that affect all patients—not just racial/ethnic minorities or patients with low socioeconomic status. However, the lack of patient-centered care may affect certain vulnerable populations disproportionately. Incorporating patients’ views on cultural competency and linguistic services into current quality measures will provide important information and give health plans and providers opportunities for improvement.

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