Culturally Competent Healthcare Systems
A Systematic Review

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Overview: Culturally competent healthcare systems—those that provide culturally and linguistically appropriate services—have the potential to reduce racial and ethnic health disparities. When clients do not understand what their healthcare providers are telling them, and providers either do not speak the client's language or are insensitive to cultural differences, the quality of health care can be compromised. We reviewed five interventions to improve cultural competence in healthcare systems—programs to recruit and retain staff members who reflect the cultural diversity of the community served, use of interpreter services or bilingual providers for clients with limited English proficiency, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials, and culturally specific healthcare settings. We could not determine the effectiveness of any of these interventions, because there were either too few comparative studies, or studies did not examine the outcome measures evaluated in this review: client satisfaction with care, improvements in health status, and inappropriate racial or ethnic differences in use of health services or in received and recommended treatment. (Am J Prev Med 2003;24(3S):68–79) © 2003 American Journal of Preventive Medicine

Introduction

The need for culturally competent health care in the United States is great: racial and ethnic minorities are burdened with higher rates of disease, disability, and death, and tend to receive a lower quality of health care than nonminorities, even when access-related factors, such as insurance status and income, are taken into account.[1] Health disparities related to socioeconomic disadvantage can be alleviated, in part, by creating and maintaining culturally competent healthcare systems that can at least overcome communication barriers that may preclude appropriate diagnosis, treatment, and follow-up. Cultural competence is an essential ingredient in quality health care (see Defining Cultural Competence in Health

Care, below). Providing culturally competent services has the potential to improve health outcomes, increase the efficiency of clinical and support staff, and result in greater client satisfaction with services.[2]

The surge of immigrants into the United States over the past 3 decades has brought a proliferation of foreign languages and cultures. Residents of the United States speak no less than 329 languages, with 32 million people speaking a language other than English at home.[3] In response to this expanding cultural diversity, healthcare systems are paying increased attention to the need for culturally and linguistically appropriate services. Cultural and linguistic competence reflects the ability of healthcare systems to respond effectively to the language and psychosocial needs of clients.[4]

Defining Cultural Competence in Health Care

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations.[5] *Culture* refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. *Competence* implies having the capacity to function effectively as an individual and an organization within the context of

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the cultural beliefs, behaviors, and needs presented by consumers and their communities.[4]

A culturally competent healthcare setting should include an appropriate mix of the following:

- a culturally diverse staff that reflects the community(ies) served,
- providers or translators who speak the clients' language(s),
- training for providers about the culture and language of the people they serve,
- signage and instructional literature in the clients' language(s) and consistent with their cultural norms, and
- culturally specific healthcare settings.

The Role of Language in Health Care

An inability to communicate with a healthcare provider not only creates a barrier to accessing health care[6–8] but also undermines trust in the quality of medical care received and decreases the likelihood of appropriate follow-up.[2] Furthermore, lack of a common language between client and provider can result in diagnostic errors and inappropriate treatment.[8] The Robert Wood Johnson Foundation recently conducted a survey of Spanish-speaking residents of the United States, which indicated that nearly one in five delayed or refused needed medical care because of language barriers with an English-speaking doctor.[9] Thirteen million Hispanics in the United States do not speak English well,[9] and they are not the only segment of our population using a language other than English. According to the Current Population Reports,[10] in March 2000 the foreign-born population of the United States was estimated to be 28.4 million—a substantial increase from the population of 9.6 million foreign-born residents in 1970, reflecting the high level of immigration over the past three decades. Half of foreign-born U.S. residents are from Latin America, one fourth from Asia, and the remainder from Europe, Canada, and other areas.[10]

Even among English-speaking clients, communication with providers is problematic. In a national survey conducted by the Commonwealth Fund, 39% of Latinos, 27% of Asian Americans, 23% of African Americans, and 16% of whites reported communication problems: Their doctor did not listen to everything they said, they did not fully understand their doctor, or they had questions during the visit but did not ask them.[11] This difficulty was compounded for clients who do not speak English: 43% of Latinos whose primary language was Spanish reported these communication problems, compared with 26% whose primary language was English.[11]

The Role of Culture in Health Care

Culture and ethnicity create a unique pattern of beliefs and perceptions as to what "health" or "illness" actually mean. In turn, this pattern of beliefs influences how symptoms are recognized, to what they are attributed, and how they are interpreted and affects how and when health services are sought. Cultural differences in the recognition and interpretation of symptoms and in the use of health services are the subject of a rich literature.[12–16] Fifty years ago Zaborowski[17] conducted a classic study on the effects of culture on pain: although pain was considered a biologic phenomenon, he found that sensitivity to pain and attributing significance to pain symptoms varied by culture and ethnicity. Almost 40 years ago Suchman[18] accounted for ethnic differences among people seeking health care as related to social structures and relationships and the degree of skepticism about professional medical care. Delay in seeking care was found among individuals belonging to cultural groups characterized by ethnic exclusivity, traditional family authority, and high skepticism about medicine. More recently, level of acculturation has been shown to account for differences in the use of health services within ethnic groups after controlling for age, gender, health status, and insurance coverage.[13,15]

Racial and Ethnic Disparities in the Processes and Outcomes of Care

Differences in referral and treatment patterns by providers (after controlling for medical need) have been shown to be associated with a client's racial or ethnic group.[1,4] Negative attitudes toward a person, based on that person's ethnicity or race, constitute racial prejudice or bias. Whether conscious or unconscious, negative social stereotypes shape behaviors during the clinical encounter and influence decisions made by providers and their clients.[19] This phenomenon has been shown in the clinical literature. For example, differences between African Americans and whites in referral for cardiac procedures,[20,21] analgesic prescribing patterns for ethnic minorities compared with nonminority clients,[22] racial differences in cancer treatment,[23] receipt of the best available treatments for depression and anxiety by ethnic minorities compared with nonminority clients,[24] and differences in HIV treatment modalities,[25] are just a few ways in which race and ethnicity can affect care. On the part of clients, delay or refusal to seek needed care can result from mistrust, perceived discrimination, and negative experiences in interactions with the healthcare system.[26–29] A recent Institute of Medicine report[30] on unequal medical treatment noted: "The sources of these disparities are complex, are rooted in historic and contemporary inequalities, and involve many participants at

Table 1. Selected *Healthy People 2010*[31] objectives related to culturally competent care interventions

Educational/community-based health programs
(Developmental) Increase the proportion of patients who report that they are satisfied with the patient education they receive from their health care organization (Objective 7–8)
Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs from 1996 to 1997 baseline data (Objective 7–11)
Programs using communication to improve health
(Developmental) Increase the proportion of persons who report that their healthcare providers have satisfactory communication skills (Objective 11-6)
Programs to improve access to appropriate, quality mental health services
(Developmental) Increase the number of states, territories, and the District of Columbia with an operational mental health plan that addresses cultural competence (Objective 18-13)

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several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and clients."

Culturally Competent Healthcare Systems

In the social environment and health logic model (described elsewhere in this supplement[31]) access to "health promotion, disease and injury prevention, and health care" serves as an intermediate indicator along a pathway linking resources in the social environment to health outcomes. An important component of access to care for culturally diverse populations is the cultural competence of healthcare systems. This is integral to healthcare quality, because the goal of culturally competent care is to assure the provision of appropriate services and reduce the incidence of medical errors resulting from misunderstandings caused by differences in language or culture. Cultural competence has potential for improving the efficiency of care by reducing unnecessary diagnostic testing or inappropriate use of services.

Healthy People 2010 Goals and Objectives

Cultural and linguistic competence in health care is integral to achieving the overarching goals of *Healthy People 2010*[32]: increasing quality and years of healthy life and eliminating health disparities.

Access to health care is a leading health indicator. Barriers to access include cultural differences, language barriers, and discrimination. Culturally competent health services improve all focus areas of *Healthy People 2010* by reducing barriers to clinical preventive care, primary care, emergency services, and long-term and rehabilitative care. *Healthy People 2010* objectives that specifically address the need to increase cultural competence in health care are described in Table 1.

National Standards for Culturally and Linguistically Appropriate Services in Health Care

In March 2001, the Department of Health and Human Services' Office of Minority Health published national standards for culturally and linguistically appropriate services (CLAS) in health care.[4] The CLAS standards (Table 2) were developed to provide a common understanding and consistent definition of culturally and linguistically appropriate healthcare services. Additionally, they were proposed as one means to correct inequities in the provision of health services and to make healthcare systems more responsive to the needs of all clients. Ultimately, the standards aim to eliminate racial and ethnic disparities in health status and improve the health of the entire population. The healthcare interventions selected for this review by the Task Force on Community Preventive Services (the Task Force) complement the recommended CLAS standards for linguistic and cultural competency by assessing the extent to which meeting some of these standards results in improved processes and outcomes of care.

Conceptual Approach

A description of the general methods used to conduct the systematic reviews for the *Guide to Community Preventive Services* (the *Community Guide*) have been described in detail elsewhere.[33] The specific methods for conducting reviews of interventions to promote healthy social environments are described in detail in this supplement.[31] This section briefly describes the conceptual approach and search strategy for interventions to promote cultural competence in healthcare systems. These interventions are designed to improve providers' cultural understanding and sensitivity, as well as their linguistic acumen and comprehension, and to provide a welcoming healthcare environment for clients.

Five interventions were selected for review:

- programs to recruit and retain staff members who reflect the cultural diversity of the community served,
- use of interpreter services or bilingual providers for clients with limited English proficiency,
- cultural competency training for healthcare providers,
- use of linguistically and culturally appropriate health education materials, and
- culturally specific healthcare settings (e.g., neighborhood clinics for immigrant populations or "clinicas de campesinos" for Mexican farmworker families).

We did not review organizational supports for cultural competence, such as policies and procedures for collecting

Table 2. National standards for culturally and linguistically appropriate services[4]

Preamble (excerpt)
The following national standards issued by the U.S. Department of Health and Human Services' Office of Minority Health respond to the need to ensure that all people entering the healthcare system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients or consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

Culturally competent care
Standard 1. Healthcare organizations should ensure that patients or consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
Standard 2. Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
Standard 3. Healthcare organizations should ensure that staff members at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language access services
Standard 4. Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient or consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
Standard 5. Healthcare organizations must provide to patients or consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
Standard 6. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff members. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer).
Standard 7. Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.

Organizational supports for cultural competence
Standard 8. Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability or oversight mechanisms to provide culturally and linguistically appropriate services.
Standard 9. Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
Standard 10. Healthcare organizations should ensure that data on the individual patient's or consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
Standard 11. Healthcare organizations should maintain a current demographic, cultural, and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
Standard 12. Healthcare organizations should develop participatory, collaborative partnerships with communities and use a variety of formal and informal mechanisms to facilitate community and patient or consumer involvement in designing and implementing CLAS-related activities.
Standard 13. Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients or consumers.
Standard 14. Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

information on race or ethnicity for accountability or incorporation into organizational performance improvement plans.

Analytic Frameworks

The conceptual model (or "analytic framework") used to evaluate the effectiveness of healthcare system interventions to increase cultural competence is shown in Figure 1. Culturally competent healthcare systems provide an array of services for clients that accommodate differences in language and culture. Services such as interpreters or bilingual providers, cultural diversity training for staff members, linguistically and culturally appropriate health education, and culturally specific healthcare settings may improve health because of the following:

- Clients gain trust and confidence in accessing health care, thereby reducing differentials in contact or follow-up that may result from a variety of causes (e.g., communication
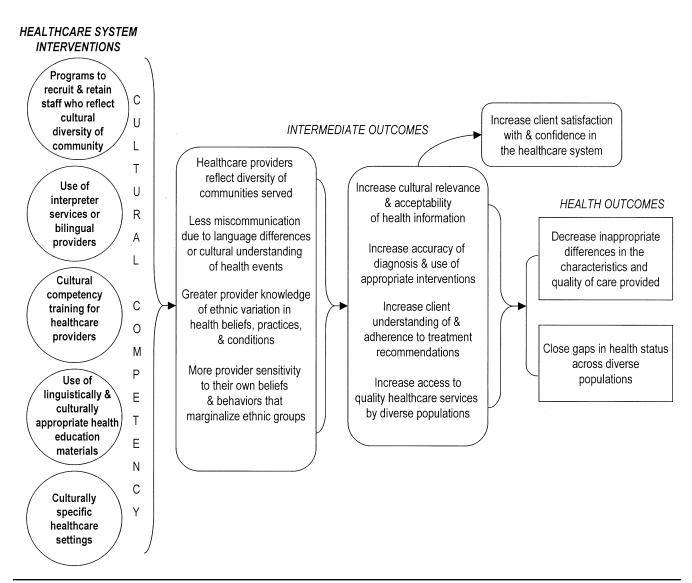
HEALTHCARE SYSTEM INTERVENTIONS

Figure 1. Analytic framework used to evaluate the effectiveness of healthcare system interventions to increase cultural competence.

difficulties, differences in understanding of health issues, or perceived or actual discrimination).

- Healthcare providers increase their ability to understand and treat a culturally diverse clientele with varied health beliefs and practices, thus improving accuracy of diagnoses and selection of appropriate treatment.

The ultimate goal of interventions to increase the delivery of culturally competent health care is to make the healthcare system more responsive to the needs of all clients and to increase their satisfaction with and access to health care, decrease inappropriate differences in the characteristics and quality of care provided, and close the gaps in health status across diverse populations within the United States.

For each intervention reviewed, the outcome measures evaluated to determine their success were

- client satisfaction with care,
- racial or ethnic differentials in utilization of health services or in received or recommended treatment, and
- improvements in health status measures.

Search Strategy

We searched eight databases for studies evaluating interventions to increase cultural competence in healthcare systems: Medline, ERIC, Sociological Abstracts, SciSearch, Dissertation Abstracts, Social Science Abstracts, Mental Health Abstracts, and HealthSTAR. Internet resources were examined, as were reference lists of reviewed articles and referrals from specialists in the field. To be included in the reviews of effectiveness, studies had to

- document an evaluation of a healthcare system intervention to increase cultural or linguistic competence,
- be conducted in an Established Market Economy,[a]

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[a]Established Market Economies as defined by the World Bank are Andorra, Australia, Austria, Belgium, Bermuda, Canada, Channel Islands, Denmark, Faeroe Islands, Finland, France, Germany, Gibraltar, Greece, Greenland, Holy See, Iceland, Ireland, Isle of Man, Italy, Japan, Liechtenstein, Luxembourg, Monaco, the Netherlands, New Zealand, Norway, Portugal, San Marino, Spain, St. Pierre and

- be published in English between 1965 and 2001,
- compare outcomes among groups of people exposed to the intervention with outcomes among groups of people not exposed or less exposed to the intervention (whether the comparison was concurrent between groups or before-and-after within groups), and
- measure outcomes defined by the analytic framework for the intervention.

The literature search yielded a list of 984 articles and reports. These titles and abstracts were screened to see if the article reported an intervention study (as opposed to studies of ethnic differentials in treatment or outcomes without an intervention component, descriptions of model programs, description of curricula for cultural competence, and so on). Based on this screening, 157 articles were assessed for inclusion. Nine articles met the inclusion criteria described here; three of these were excluded because of threats to validity. The remaining six studies were considered qualifying studies (see Evaluating and Summarizing the Studies[31]) and the findings of this review are based on those studies.

Intervention Effectiveness and Economic Efficiency
Programs to Recruit and Retain Staff Members Who Reflect the Cultural Diversity of the Community Served

Workforce diversity in the healthcare setting is seen as a means of providing relevant and effective services. Workforce diversity programs go beyond hiring practices to include organizational strategies for identifying barriers that prevent employees from fully participating and achieving success. Achieving diversity at all levels of the healthcare organization can influence the way the organization serves the needs of clients of various cultural and linguistic backgrounds. For this review, we searched for healthcare system interventions to recruit or retain diverse staff members.

Review of evidence

Effectiveness. No comparative studies evaluated these programs. Therefore, evidence was insufficient to determine the effectiveness of healthcare system interventions to recruit and retain diverse staff members.

Use of Interpreter Services or Bilingual Providers for Clients with Limited English Proficiency

Clients should be able to understand the nature and purpose of the healthcare services they receive. Accurate communication increases the likelihood of receiving appropriate care, both in terms of the best technical care for symptoms or conditions and in terms of client preferences. Language capacity varies: for example, a person may understand enough English to complete an intake form but may need considerable help to understand diagnosis and treatment options. Or an English-speaking provider may know basic vocabulary or medical terminology in the client's language but may lack understanding of the cultural nuances that affect the meaning of words or phrases. In the healthcare setting, non–English-speaking clients can be assisted by family members, by staff members with other primary duties who act as interpreters, or by professionally trained interpreters (whose training in medical terminology and confidentiality may both prevent communication errors and protect privacy).

We searched for studies that examined the effectiveness of bilingual providers, bilingual staff members who serve as interpreters (in addition to their regular duties), and professionally trained interpreters on improving three outcomes: client satisfaction, racial or ethnic differentials in utilization and treatment, and health status measures.

Review of evidence

Effectiveness. Our search identified two studies[34,35] that examined the effectiveness of using bilingual providers and interpreter services and met *Community Guide* study design criteria.[33] One of these studies[35] had limited quality of execution and was not included in the review. The remaining study, of greatest design suitability and fair execution, was conducted in an urban hospital emergency department serving predominantly Latino clients (74%). The subjects were predominantly female (64%), between 18 and 60 years of age (92%), and uninsured (68%). The study excluded clients presenting with overt psychiatric illness and those too ill to complete an interview. The intervention conditions evaluated were language concordance between physician and client or use of an interpreter (both professionally trained and untrained). Assignment to an encounter with an interpreter was based on the physician's or nurse's subjective assessment of his or her own Spanish proficiency and the client's English proficiency. A comparison group consisted of Spanish-speaking clients who reported that an interpreter was needed but not used. Differences in effect based on whether the interpreter was professionally trained (12%) or was a family member or hospital staff member serving as an ad hoc interpreter (88%) were not reported. Details of this study are summarized in Appendix A.

Outcomes examined were receipt of referral for, and adherence to, a follow-up appointment. After adjusting for socioeconomic characteristics and physician's discharge diagnosis, those clients who reported that an interpreter was needed but not used were more likely to be discharged without a follow-up appointment than clients with language-concordant physicians (OR=1.79, 95% confidence interval [CI]=1.00–3.23). Similarly, those clients who communicated through an interpreter were more likely to be discharged without a

follow-up appointment than clients with language-concordant physicians (OR=1.92, 95% CI=1.11–3.33). However, people in the intervention groups were no more likely to adhere to appointments than were controls.

Conclusion. According to *Community Guide* rules of evidence,[33] available studies provide insufficient evidence to determine the effectiveness of using interpreter services or bilingual providers for clients with limited English proficiency. Evidence was insufficient because only one comparative study, with fair quality of execution, assessed outcomes relevant to this systematic review.

Cultural Competency Training for Healthcare Providers

A person's health is shaped by cultural beliefs and experiences that influence the identification and labeling of symptoms; beliefs about causality, prognosis, and prevention; and choices among treatment options. Family, social, and cultural networks reinforce these processes. Cultural competency includes the capacity to identify, understand, and respect the values and beliefs of others.

Cultural competency training is designed to (1) enhance self-awareness of attitudes toward people of different racial and ethnic groups; (2) improve care by increasing knowledge about the cultural beliefs and practices, attitudes toward health care, healthcare-seeking behaviors, and the burden of various diseases in different populations served; and (3) improve skills such as communication. We searched for studies that examined the effectiveness of cultural competency training programs for healthcare providers on improving outcomes of client satisfaction, racial or ethnic differentials in utilization and treatment, and health status measures.

Review of evidence

Effectiveness. Our search identified one study[36] that examined at least one of the outcomes described above and met *Community Guide* study design criteria.[33] This study was of greatest design suitability and fair execution. The intervention setting was a metropolitan college mental health center. The 80 subjects were lower-income African-American women, with a mean age of 38 years, who resided in the community. They were referred to the counseling clinic by area social services agencies or were self-referred. The intervention consisted of 4 hours of cultural sensitivity training for four counselors (two white and two African American). Four other counselors (two white and two African American) received usual training. Clients in the intervention group reported greater satisfaction with counseling than did controls (standard effect size=1.6, $p<0.001$),

independent of the race of the counselor. Clients were asked to return for three follow-up visits; those assigned to the intervention group returned for more sessions than did those assigned to the control group (absolute difference=33%, $p<0.001$). Details of this study are summarized in Appendix A.

Conclusion. According to *Community Guide* rules of evidence,[33] evidence was insufficient to determine the effectiveness of cultural competence training programs for healthcare providers because only one qualifying study, with fair quality of execution, was available.

Use of Linguistically and Culturally Appropriate Health Education Materials

Culture defines how health information is received, understood, and acted upon. Language is a powerful transmitter of culture. Nonverbal expression differs among ethnic groups. Health information messages (i.e., print materials, videos, television or radio messages) developed for the majority population may be inaccessible or unsuitable for other cultural or ethnic groups.

Culturally and linguistically appropriate health education materials are designed to take into account differences in language and nonverbal communication patterns and to be sensitive to cultural beliefs and practices. We searched for studies that examined the effectiveness of linguistically and culturally appropriate health education materials on improving outcomes of client satisfaction, racial or ethnic differentials in utilization of services or treatment, and health status measures.

Review of evidence

Effectiveness. Our search identified six studies[37–42] that examined the effectiveness of interventions that provided culturally and linguistically appropriate health education materials and met *Community Guide* study design criteria.[33] Two of these studies[41,42] had limited quality of execution and were not included in the review. The remaining four studies[37–40] were of greatest design suitability, and, of these, one had good quality of execution and three had fair quality. All four studies examined the effectiveness of culturally sensitive health education videos: three[37,38,40] were conducted among African-American populations and one[39] in a population that was 41% African American and 45% Latino. Three studies[37,38,40] examined HIV knowledge, attitudes, or behaviors—two among adults and one among adolescents. The remaining study[39] examined tobacco use knowledge and behavior among adolescents. Details of these studies are summarized in Appendix A.

The cultural communication techniques used in the videos included race or ethnic concordance between

actors and the target audience, messages targeted specifically to African Americans versus multicultural messages, and similarity in contemporary music and dress between actors and the target audience. Of the four studies reviewed, one[40] reported a change in health behavior: African-American women exposed to a video specifically designed to emphasize culturally relevant values had an 18% increase ($p<0.01$) in self-reported HIV testing in a 2-week period after the intervention. The remaining studies included measures of satisfaction with the cultural relevance of the videos. Significant positive differences in satisfaction with the educational video[38] and credibility of content and attractiveness of announcer[37] were reported. One study[39] reported no difference in preference for a "rap" format video targeted to African-American youth over a standard video.

Conclusion. According to *Community Guide* rules of evidence,[33] available studies provide insufficient evidence to determine the effectiveness of interventions to provide linguistically and culturally appropriate health education materials because only a small number of comparative studies, with limitations in execution, assessed outcomes relevant to this systematic review.

Culturally Specific Healthcare Settings

Healthcare settings may raise both linguistic and cultural barriers for ethnic subgroups, particularly recent immigrants with limited acculturation to majority norms and behaviors. Limited English language proficiency and lack of ethnic match between staff members and client may decrease or delay healthcare-seeking behavior. For this review we searched for studies that evaluated the effectiveness of culturally or ethnically specific clinics and services, located within the community served.

Review of evidence

Effectiveness. No comparative studies evaluated these programs. Therefore, data were insufficient to determine the effectiveness of interventions to deliver services in culturally or ethnically-specific settings.

Research Issues for Improving the Cultural Competence of Healthcare Systems

The Task Force found an insufficient number of qualifying evaluation studies to allow conclusions about the effectiveness of interventions to improve the cultural competence of healthcare systems, highlighting the need for more, and better, research in this area. Research is needed to assess intervention effectiveness in changing the structure and process of healthcare delivery. This research must examine meaningful health outcomes and focus on what works best, where,

and for whom. Demonstrating differential effectiveness for specific subgroups of clients can help tailor interventions for maximum impact. The idea that "one size fits all" is contradictory to the very notion of cultural diversity.

Basic questions remain about the potential of the interventions reviewed here to improve satisfaction with care, reduce ethnic differentials in utilization and treatment, and improve health status. We noted an absence of comparative research, specifically studies in which interventions to improve cultural competence are compared with usual care alternatives. Evaluation studies must assess not only change in knowledge and attitudes but also use of services, receipt of treatments, and changes in health outcomes. Much remains to be learned about the effectiveness of, unintended consequences of, and potential barriers to the types of interventions reviewed here.

Effectiveness

The ability to communicate in the clinical encounter is critical to good medical outcomes. Not all communications problems are attributable to language barriers. Effectiveness studies must take into account the additional effect of language on existing provider–client communication patterns.

In 1964, the Civil Rights Act, Title VI, mandated provisions for the language needs of clients.[43] Healthcare organizations cite cost as an important factor that limits their ability to provide trained interpreters. Very little research has been done on the effectiveness and cost-effectiveness of providing linguistically competent healthcare services in the United States or on ways to reduce the costs of providing such services. Questions such as the following need to be answered.

- Do trained interpreters compare favorably with family or ad hoc staff interpreters in improving outcomes of satisfaction, appropriate utilization, and health status?
- What are the relative contributions of improvements in linguistic competence and cultural sensitivity skills to reducing miscommunication and the resulting medical errors?
- Are linguistically and culturally appropriate health education materials more effective than standard materials in improving health outcomes?

Healthcare providers and provider organizations are concerned about the burden placed on resources by implementing interventions to improve the cultural competence of healthcare systems, particularly in the absence of proven effectiveness. Answers to the following questions should be sought:

- What role should communities play in collaborating with area healthcare organizations to communicate the needs of ethnically diverse populations?

- At what levels (e.g., management, provider, staff) in a healthcare organization does investment in linguistic and cultural competencies create the greatest improvement in health or other outcomes?
- Which cultural competencies within a healthcare system increase client satisfaction and improve health outcomes?
- Does cultural competency training of healthcare providers have a lasting effect or should it be repeated periodically?

Other Positive or Negative Effects

- Do ethnic-specific health messages generate negative stereotypes?
- Do the client benefits of engaging in culturally competent healthcare systems carry over to other social institutions (e.g., education, employment)?

Cultural competence is increasingly important for healthcare quality. The burgeoning interest in culturally competent model programs is apparent in the healthcare literature, but a research base on program effectiveness to inform decision making is absent.

Summary: Findings of the Task Force

The effectiveness of five interventions to improve the cultural competence of healthcare systems could not be determined in this systematic review, because of a lack of both quantity and quality of available studies. We found no comparative studies evaluating (1) programs to recruit and retain staff members who reflect the cultural diversity of the community served or (2) the use of culturally specific healthcare settings; only one qualifying study each (with fair quality of execution) evaluating (1) use of interpreter services or bilingual providers for clients with limited English proficiency or (2) cultural competency training for healthcare providers; and only four qualifying studies (three with fair quality of execution) evaluating the use of linguistically and culturally appropriate health education materials. Additional research, as suggested above, is needed to determine whether or not these interventions are effective in improving client satisfaction with care received, improving client health, and reducing inappropriate racial or ethnic differences in use of health services or in received or recommended treatment.

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Appendix A: Studies measuring the effectiveness of interventions to improve cultural competence

Study & year Design suitability Execution quality	Intervention	Measures used (sample size)	Measurement time	Effect* (*p* value)
Sarver & Baker, 2000[1] Suitability: Greatest Execution: Fair	Setting: Urban hospital emergency room Population: English- and Spanish-speaking patients Intervention conditions: I-1) language-concordant provider I-2) interpreter used I-3) interpreter needed, not used	Outcome measures: 1) referral for follow-up appointment 2) follow-up appointment compliance (*n* = 1680)	6 mo post intervention	Referral for follow-up visit: I-1: 83% I-2: 76% I-3: 75% (*p* <.05) Appointment compliance: I-1: 60% I-2: 54% I-3: 64% (*p* = .40)
Wade & Bernstein, 1991[2] Suitability: Greatest Execution: Fair	Setting: Counseling center on metropolitan college campus. Intervention: 4 hours of cultural sensitively training for counselors (2 African American, 2 Euro American) Control: counselors with usual training (2 African American, 2 Euro American)	Outcome measures: 1) scale rating satisfaction with care 2) completion of 3 counseling sessions (*n* = 80)	Follow-up at 2 wk to 3 mo post intervention	Client satisfaction with care: Standard effect size 1.6 (*p* <.001) Percent attending 3 sessions: 33% difference (*p* <.001)
Herek et al., 1998[3] Suitability: Greatest Execution: Good	Setting: Urban Population: African American Mean age: 37, 56% female Low income 2 groups at community center 1 group at college campus Intervention conditions: HIV/AIDS educational videos: 1) Black announcer (BA), multicultural message 2) Black announcer, culturally specific message 3) White announcer (WA), multicultural message	Outcomes measures: Scale rating credibility and quality of video, attractiveness of announcer (*n* = 490)	After viewing video	BA rated more credible, better quality than WA (*p* <.001); insufficient data to compute effect size. BA with culturally-specific message rated more attractive than WA or BA with multicultural message (*p* <.05); insufficient data to compute effect size. No significant differences across groups in risk reduction intentions or intention to be tested for HIV
Kalichman et al., 1993[4] Suitability: Greatest Execution: Fair	Population: Low income, African-American women, mean age 32 years Intervention conditions: 1) standard AIDS video 2) video matching race and gender 3) video matching race and gender, and culturally-specific message	Having HIV test within 2 weeks after intervention (*n* = 106)	2 wk post intervention	Culturally-specific message group: 18% reported HIV testing None tested in other 2 groups
Stevenson, 1994[5] Suitability: Greatest Execution: Fair	Setting: Urban Summer school Population: 14–15-year-old African-American students Intervention: HIV/AIDS video similar in race and culture compared with dissimilar video	Student questionnaire rating of video (N = 121 students, 4 classes)	After viewing video	Culturally similar video rated more favorably Effect size 1.7 (*p* = .04) No behavioral outcomes
Sussman, 1995[6] Suitability: Greatest Execution: Fair	Setting: Urban school Adolescents, mean age 12.3 years. 41% African American, 45% Latino Rap format video compared with standard video on tobacco use prevention	Student questionnaire rating video cultural sensitivity and likeability. (N = 267 7th grade students in 3 schools)	After viewing video	Perception of cultural sensitivity: rap format video rated more accurate portrayal of African-American culture (*p* <.05); insufficient data to compute effect size. No difference in likeability by ethnicity

* Standard Effect Size: (Mean I - Mean C / Standard deviation C
  Percent difference: (Percent I - Percent C), where I=intervention group, C=control group

Appendix continued

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