

## Cultural Competence in Health Care: Another Aspect of Kaiser Permanente's Commitment to Quality

***During 1997, the first handbook on delivering culturally competent care to a distinct set of ethnic populations, Latinos, was published under the sponsorship of the National Diversity Council. This is the first of a series of handbooks that summarizes epidemiologic data, health beliefs, and cultural characteristics that have implications for service delivery to special populations.***

Carlos, an 11-year-old Mexican American, has been newly diagnosed with acute myelogenous leukemia. His physician feels it is important to include the boy in discussions about his disease, its treatment and its prognosis. The parents, Jesus (who speaks English well) and Elena (whose English is limited), are horrified at this suggestion and adamantly refuse to allow this discussion.

A medical director of a large Kaiser Permanente medical center located in the Southwest is concerned that the proportion of members with non-insulin-dependent diabetes mellitus (NIDDM) is significantly higher in that service area than in other areas in the division. This presents a cost-containment challenge, because, according to the National Medical Expenditure Survey, per-patient annual expenditures for diabetic patients are 3 to 4 times greater than for non-diabetic patients. The sizable proportion of diabetic patients also means that a great deal of effort will be required to meet the Health Employer Data Information Set (HEDIS)-driven clinical goals around retinal screening and proportion of diabetic members with good blood sugar control. Recently, the marketing director reported studies indicating that African Americans make up about 20% of local Southwest market members and that Latinos comprise 52%. About 65% of the babies born in the hospital are Latino.

Although at first glance the problems confronting the physician and the medical director appear to have little in common, more careful consideration reveals that they share a common thread: both are related to the unique cultural and medical needs of a specific population. Effectively addressing these needs will require skills currently being called "cultural competence." In a recent editorial in the *Annals of Internal Medicine* (May 1996), cultural competence in health care is defined as "the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy." Adopting this perspective, the National Diversity Council's handbook series on culturally competent care is designed to help individual physicians work more effectively

with members from specific cultural backgrounds. The books also provide epidemiological data that will aid persons who are planning service delivery strategies and systems.

Familiarity with Mexican family roles and caretaking behavior would enable Carlos' physician to manage the impasse with the parents more persuasively. The medical director will understand that the members consist primarily of two very different populations with very high prevalence of NIDDM. This understanding may lead to assessment of language needs and availability of educational and outreach materials in Spanish. Spanish-language classes and Spanish-speaking nurses may also facilitate patient understanding and compliance. Approaches to both populations, including recommended dietary and lifestyle changes, may be more effective if they are given in a culturally relevant context. In the long run, such a culturally sound approach has the potential for reducing costs related to the expensive sequelae of this disease.

### Background

#### Why the focus on specific groups now?

The United States is currently experiencing the second-largest wave of immigration in its history. Shaped by changes in immigration regulations, refugee resettlement, amnesty for undocumented immigrants, and global economics and politics, large numbers of persons from non-Western cultures are making this country their home. The new entrants are immigrants from all levels of educational and class background.

America's earlier immigrants came primarily from Europe, and their cultures, though variant, had much in common with each other and with people already living in the U.S. The major exception to this, of course, was the forced immigration of Africans under slavery.

Recent newcomers may be from cultures with a history of long-standing medical traditions, such as Ayurvedic or classical Chinese, of folk medicine, a different set of popular (read "over the counter") practices or, most likely, a mixture of biomedicine and several of these. Their health care practices are guided by a wide variety of beliefs about anatomy, etiology, and symptomatology. These beliefs have in turn been shaped by morbidity and mortality patterns in their places of origin, by diet and food supply, by differing disease vectors, and by variation in health care policies.

Cultural orientations around death and dying and around pain and suffering also guide decision-making

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as do varying concepts of gender roles, and sexual and reproductive practices. For example, physicians who are now seeing an increasing number of female patients from African nations find it hard to understand the belief systems that underlie the practice of female circumcision. However problematic such practices seem, they are deeply embedded in their practitioners' social reality and moral system.

Different groups also have distinctive beliefs about appropriate ways to interact with physicians, nurses, pharmacists, and other health care personnel and may have expectations about how they should be treated in the health care setting. As with all groups, they bring to the medical encounter the "invisible" culture of norms, values, and behaviors that affect their acceptance or rejection of treatment, prevention strategies, and their judgment of health care systems and personnel.

### The Race/Ethnic Variable in Epidemiology

Along with age and gender, race and ethnicity are variables which are critical in defining risk factors and epidemiology patterns across groups. National studies of disease incidence and prevalence show statistically significant differences in the occurrence of many major diseases along race and ethnic lines. The reasons for this systematic variation are complex.

Some disorders have a hereditary basis, such as sickle cell disease in African Americans, Tay Sachs disease in Ashkenaz Jews, alpha- and beta-thalassemia in many Asian and Pacific Islander populations, neural tube defects in Southeast Asians, and NIDDM in some American Indian groups and in groups of American Indian mixture. On the other hand, some diseases hypothesized to be genetically linked, such as nasopharyngeal cancer among Chinese persons, may also involve cultural (especially dietary) factors in their etiology.

Social epidemiology—the study of how culture affects the onset, course, treatment, and outcome of disease—demonstrates that a cultural group's beliefs, behavioral norms, and practices greatly affect its health status. Sexual norms prescribing who may have relations with whom, when, and how affect the transmission of STDs. For example, bisexuality and homosexuality are defined and understood differently across cultures, and norms governing heterosexual and same-sex intercourse vary widely. Dietary beliefs and customs affect the prevalence of hypertension, heart disease, and diabetes. Differing values related to beauty and body size affect acceptance of obesity. Adhering to or rejecting treatment may turn on how well the regimen is integrated with cultural understandings and social customs that are not well understood outside a patient's culture.

Finally, disease patterns are sometimes linked to a specific group's socioeconomic position through environmental factors and differential access. The prevalence of lead poisoning among African American and Latino children living in older buildings in inner cities is a case in point. High levels of asthma among inner-city dwellers are hypothesized to be linked to environments containing exceptionally high levels of pollutants.

The National Diversity Council's handbooks on culturally competent care highlight these differences in epidemiologic patterns across groups and draw implications from them for planning service delivery and patient care. Cultural beliefs and orientations that may impact health care utilization and treatment adherence are also discussed. Major groups within the glosses "Latino," "African American" and "Asian" are distinguished.

### Special Treatment or Quality Care?

Many health care professionals are concerned about focusing on ethnic differences among patients, saying that patients want to be treated the same regardless of background. They are rightfully fearful of stereotyping. A very small minority of physicians see a disease process as being the same in all patients, whatever the factors that have provoked its onset or mediate its course and treatment.

Patients from specific groups often do state that they want "the same treatment as others." Questioned, they mean the same good treatment, treatment of equal quality to that which others receive. What they do not mean is that their beliefs and life circumstances should be ignored or that a one-size-fits-all approach should be taken.

The paradox is that in order to provide the highest quality of care to persons from all groups in Kaiser Permanente's membership, knowledge of epidemiological, cultural and linguistic factors that may affect their health status, that is, group differences, is important.

The handbooks sponsored by the National Diversity Council present information on different groups as statistical probabilities and as generalizations based on research studies. Also presented are factors that effect important intragroup variation.

### Changes in the Regulatory/Legal Environment

The importance of physiological and cultural variation as it impacts health care status has attracted the attention of regulatory and accrediting agencies. Many states which send Medicaid recipients into managed care programs (such as California, New York, New Jersey, Illinois, Massachusetts, Rhode Island, and Wash-

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ington) have written cultural and linguistic requirements into their contracts, usually to be triggered by defined concentrations of specific groups within service areas. Foremost among these stipulations is the cultural training of health care providers who care for these patients. The Health Care Financing Administration is currently studying these issues in relation to Medicare risk eligibles. As more of the nation's medically underserved children (and their parents) come into Kaiser Permanente medical offices through the new federal and state programs as well as through our own Kaiser Cares for Kids program, the diversity of our patient population will grow.

The National Committee for Quality Assurance, in its first HEDIS for Medicaid-capitated beneficiaries, includes the assessment of cultural-group concentrations and tracking of language needs. The Joint Commission for the Accreditation of Healthcare Organizations recommends cultural training for health care professionals. And, finally, *The Wall Street Journal* reported in September 1997 that some medical malpractice insurers were offering 2% to 5% premium discounts to doctors who attended a workshop on cultural differences in medicine!

In response to these needs, medical schools such as Stanford University School of Medicine and the Robert Wood Johnson School of Medicine are incorporating cross-cultural medicine in their curricula, and the family practice educators have developed a detailed training curriculum in this area. Kaiser Permanente's *Handbook on Culturally Competent Care, Latino Population* has drawn high praise from Professor Ronald Garcia, MD, of Stanford and Professor Robert Like, MD, of Robert Wood Johnson.

### **Market-Leading Performance**

Attention to the needs of specific groups that make up the Kaiser Permanente membership is another way to demonstrate market-leading performance and

make clear our organization's social purpose. It will also enhance our attractiveness to segmented markets of health care consumers.

Perhaps as important, a heightened awareness of the cultural aspects of health care enriches the practice of medicine. In the words of one physician upon reviewing a handbook manuscript, "This is fascinating stuff. Throughout human history health and healers have been central to all civilizations. I have learned so much from my patients from different cultures, not just about medicine, although that is important, but about how people adapt to different circumstances, how they can learn and change. How people see their bodies and their functioning tells us a lot about how they see life."

The provider's handbooks on culturally competent care are an integral part of the National Diversity Council's Strategic Action Plan for Diversity. The Council views the diversification of the United States population as an opportunity to focus on quality health care for specific markets and members. Driven by data that verify the large number of cultural groups among Kaiser Permanente's current and potential membership, the handbooks offer practical information in highly readable format. Funded and administered by the diversity department at Program Offices, each handbook is well researched, extensively reviewed, and accompanied by a reference list of the best publications available. The review panel for each handbook consists of a physician champion and physician reviewers, all particularly familiar with the groups being considered. The material is researched and prepared by doctoral-level students, overseen by the series editor (this author), and submitted to the review panel for suggested revisions. The final draft goes through the same exhaustive peer review process. Publication of the African American handbook is projected for February 1998, and the Asian American handbook will be available in early spring 1998. ❖