AETNA FOUNDATION  
AETNA 2001 QUALITY CARE RESEARCH FUND

EXECUTIVE SUMMARY

Project Title:  "Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods"

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Grantee:        Center for Healthy Families and Cultural Diversity  
Department of Family Medicine  
University of Medicine and Dentistry of New Jersey  
(UMDNJ) - Robert Wood Johnson Medical School

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Providing more culturally competent health care has been proposed as a key strategy for reducing racial and ethnic health disparities. The Center for Healthy Families and Cultural Diversity at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School (UMDNJ-RWJMS) (http://www2.umdnj.edu/fmedweb/chfcd/index.htm) has been actively involved in providing training about cultural competency and racial and ethnic health disparities, and employing quality improvement methods to evaluate the impact of practice interventions.

The primary aim of this Aetna Foundation-funded study was to assess whether integrating a cultural competency training program into ongoing quality improvement activities at two large urban family practices affiliated with a medical school would result in:

- Improved physician knowledge, skills, attitudes, and comfort levels relating to the care of patients from diverse backgrounds; and
- Increased patient satisfaction with cross-cultural primary care clinical encounters.

A secondary aim was to learn more from physicians, staff, and patients about the challenges involved in meeting the United States Department of Health and Human Services (USDHSS)/Office of Minority Health's (OMH) Culturally and Linguistically Appropriate Services (CLAS) Standards.

The key questions that shaped the project’s specific aims were as follows:

1. What are the views and perspectives of physicians, staff, and patients on addressing the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care in a family practice setting?
2. Does a cultural competency training program result in improved physician knowledge, skills, attitudes, and comfort levels relating to the care of patients from diverse backgrounds?
3. What impact does patient request fulfillment have on patient satisfaction with cross-cultural clinical encounters?
4. How were participatory quality improvement activities and methods utilized to address the care of patients from diverse backgrounds?

To answer these questions, we employed qualitative and quantitative methods in four corresponding substudies to develop a richer and deeper understanding of how cultural competence can be effectively incorporated into organizational and clinical practice.
• **Substudy 1. Addressing the CLAS Standards** – Four Depth Interviews were held with the Medical Directors and Practice Managers; and six Focus Group Interviews were conducted with physicians, staff, and patients at the two study sites.

• **Substudy 2. Increasing Clinical Cultural Competency** – A *Cultural Competency for Health Care Providers Training Program*, a series of five, 1.5 hour interactive seminars and workshops was presented to faculty physicians, residents, and medical students over an eight-month period. A *Clinical Cultural Competency Questionnaire (CCCQ)* was administered prior to and one year after training to 17 faculty physicians from the two practice sites.

• **Substudy 3. Providing Patient-Centered Care** – A trend analysis design was utilized, and two self-administered surveys, the *Patient Request for Services Schedule (PRFSS)* and *Patient Services Received Schedule (PSRS)* were completed by 1,004 patients at the two study sites immediately prior to and after clinical encounters over a fifteen-month period.

• **Substudy 4. Improving Quality in Primary Care Practice Settings** – Field notes were kept and participant observation carried out during a series of six facilitated Participatory Quality Improvement (PQI) team meetings held at each of the two practice sites after the cultural competency training was completed.

These substudies revealed both important and significant findings about the complexity and multifaceted dimensions of addressing clinical and organizational cultural competence in primary care practice settings. Major outcomes include:

• Practice-based research, although increasingly challenging, can be successfully carried out in busy primary care settings, if attention is paid to 1) obtaining the support and buy-in of leadership and champions, 2) identifying the appropriate personnel, technological, and financial resources, and 3) carefully planning, implementing, and executing the study.

• Primary care practice settings are complex adaptive systems and cultural competence needs to be addressed at the clinical, organizational, and systems levels, using participatory approaches.

• Multimethod assessment strategies can provide us with a richer and deeper understanding of cultural competence, patient-centered care, and quality improvement in primary care practice settings.
• Quantitative and qualitative tools exist that can help us to measure physicians' self perceived cultural competence as well as patients' expression of need, perceived receipt of services, and satisfaction with clinical encounters.

• Patients, staff, and physicians, although initially not fully aware of the CLAS standards, are highly interested in learning about ways to infuse cultural competence into patient care delivery systems. Significant challenges exist, however, given ongoing environmental, organizational, and fiscal stresses, multiple competing demands, and periodic turnover of office personnel.

• Physicians’ self-perceived cultural competence knowledge, skill, and comfort levels increased significantly. Some caution is needed though in attributing the positive changes seen to the training intervention per se, given the lack of an experimental design or control group, the small sample size of participating physicians, variable attendance at the training seminars, and other potential organizational and environmental influences.

• A significant correlation exists between fulfillment of patients’ requests and patient satisfaction with clinical encounters. Preliminary results suggest possible health care disparities – for example, that Hispanics/Latinos are less likely to see their own family physician, and that Blacks have more unfulfilled requests for services. There is an important need, however, to do more detailed analyses to further explore these findings.

• While patients’ perceptions of satisfaction are exceptionally positive, the extremely high scores may mask important underlying trends and relationships that warrant further investigation.

• Quality improvement (QI) teams can successfully improve the provision of culturally responsive care in a clinical setting. Future work by QI teams and researchers could benefit from self-reflection and application of the Participatory Quality Improvement (PQI)© model with its focus on the "clinical and cultural value compasses" as a mechanism for organizing, prioritizing, implementing, and sustaining teams’ ongoing improvement efforts.

Although relatively inexpensive to execute, the continuation of efforts to employ the CCCQ to study knowledge, skills, and attitudes of physicians and other health care providers with respect to cultural competence could have several noteworthy payoffs. First, the CCCQ instrument could be enhanced, revised, and widely disseminated. Second, the systematic analysis of additional data could lead to better understandings of cultural competency issues in general.
And third, the systematic collection of CCCQ data, perhaps with carefully controlled research designs and organized in meta-analyses, could expand on the important changes noted here in a simple pre-post training design and improve the process of evaluating the effectiveness of cultural competence training programs in particular.

Similarly, future studies should benefit from utilizing the PRFSS and PSRS instruments developed here and that gave rise to several promising findings. In addition to our intention to widely disseminate the rich set of quantitative findings reported here, an inexpensive but highly-efficient first step would certainly be to continue with the analysis of the current data, with special attention to the analysis of inter-physician differences. At the same time, some modestly-sized but carefully executed studies such as the current research design could also lead to refinements of the already solid instrumentation and be used in other settings. Such efforts might be fruitfully extended to include other racial and ethnic groups or specific diseases and conditions that might be amenable to efforts to improve culturally competent care (e.g., cardiovascular disease, diabetes, cancer, infant mortality, and mental illness). Also, and perhaps in relatively small but distinct efforts, attention focused on making the request-fulfillment data available on a more real-time basis may enable the results from these two instruments to be more immediately useful for quality improvement efforts.

Our study findings should be of interest to health care organizations in addressing the CLAS Standards, as well as to other key stakeholders and constituency groups including patients/consumers/advocates, clinicians, educators, researchers, quality improvement and risk management professionals, administrators, business/industry, and health care policy makers. Interest in eliminating disparities in health care and providing culturally competent care may well be reaching the “tipping point,” with major efforts underway throughout the United States and around the world. We hope that the insights gained from our Aetna 2001 Quality Care Research Fund study, “Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods,” will help inform future research, educational, service, and policy initiatives in this dynamic and vitally important field.