APHA 135th Annual Meeting and Exposition
November 5, 2007

Session #3206.0
Community Healthcare Delivery: Cultural Competence and Health Literacy

Generating Evidence-Based Data on the Clinical Utility of Increasing Cultural Competency Among Health Care Providers Serving Medically Underserved Areas

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Office of Minority Health and Health Disparities

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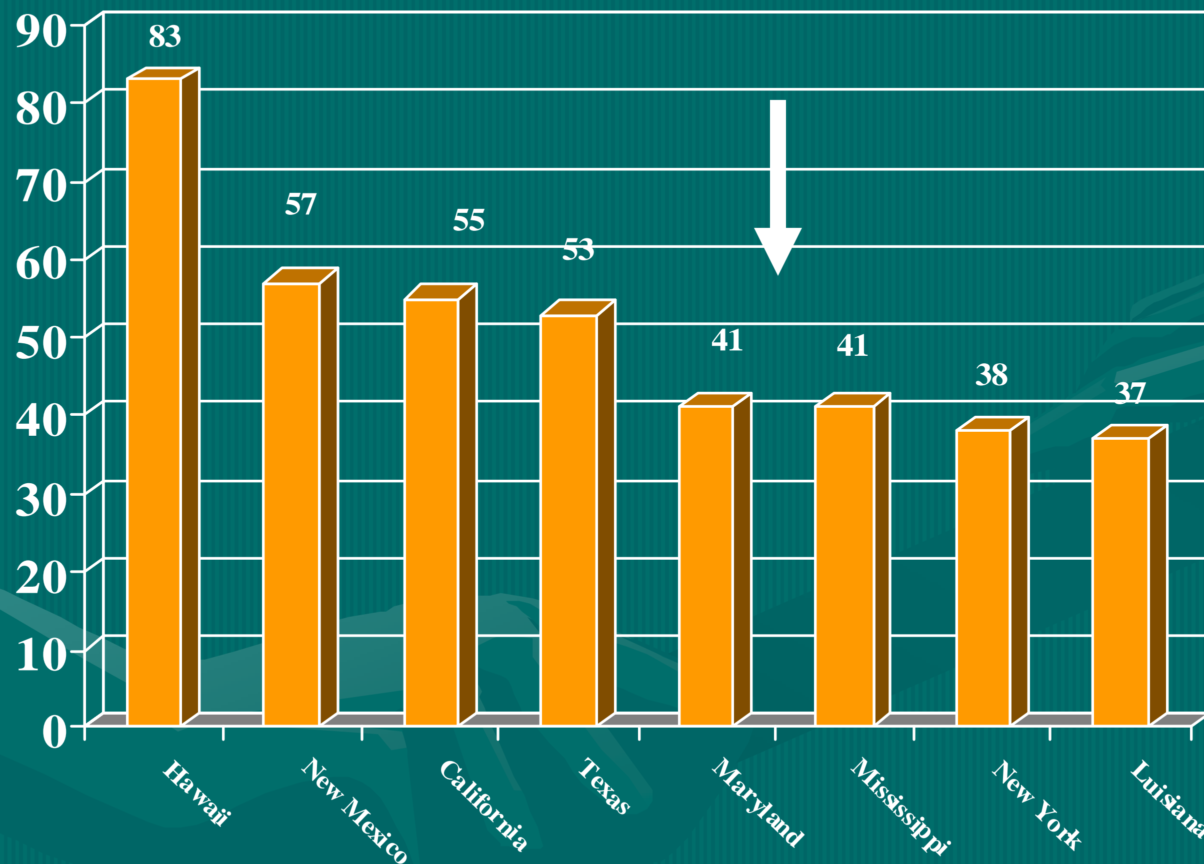
U.S. States Ranked by Percent Minorities



Minority

Kaiser Family Foundation
2003-2004

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Percent of Population that is Racial or Ethnic Minority, by Jurisdiction, Maryland 2006

Garrett 447
Allegany 5,844
Washington 18,975
Carroll 11,487
Frederick 39,422
Baltimore 252,277
Harford 41,730
Cecil 8,833
Baltimore City 440,501
Howard 91,475
Montgomery 411,951
Kent 4,067
Anne Arundel 114,921
Queen Anne's 4,954
Caroline 6,249
Prince George's 687,168
Talbot 6,459
Charles 61,860
Calvert 15,362
Dorchester 9,677
Wicomico 26,892
St. Mary's 19,639
Worcester 8,723
Somerset 11,327

Maryland Counties	% Racial/Ethnic Minority
Prince George's	81.7%
Baltimore City	69.8%
Montgomery	44.2%
Charles	44.1%
Somerset	43.9%
Howard	33.6%
Baltimore	32.0%
Dorchester	30.6%
Wicomico	29.2%
Anne Arundel	22.6%
Kent	20.4%
Saint Mary's	19.9%
Caroline	19.2%
Talbot	17.9%
Worcester	17.9%
Frederick	17.7%
Calvert	17.3%
Harford	17.3%
Washington	13.2%
Queen Anne's	10.7%
Cecil	8.9%
Allegany	8.0%
Carroll	6.7%
Garrett	1.5%
Maryland Total	**41.0%**

% Racial/Ethnic Minority

- 0% - 9.9%
- 10% - 17.9%
- 18% - 29.9%
- 30% - 100%

Date Map Created: September 2007

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DHMH – Office of Minority Health and Health Disparities

- The Maryland 2004 Legislative Session, enacted House Bill 86 and Senate Bill 177, officially establishing Maryland's Office of Minority Health and Health Disparities, in the Office of the Secretary of the Department of Health and Mental Hygiene effective October 1, 2004.
- During Maryland's 2003 Legislative Session, HB 883 paved the foundation for Maryland's Health Care Disparities Initiative that is interwoven within HB 86 and SB177.

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HB 1455
(2006 Session)

Requires the Maryland's Department of Health and Mental Hygiene to provide technical assistance to qualified community-based hospitals for a pilot program that addresses:

1. Cultural competency training for health care providers with an emphasis on community-based providers and
2. Health outcomes and community-based models for targeting [specific] health outcomes

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Cultural Competence in Health Care: The Need

- Nearly 53 million Americans speak languages other than English
- One in three Americans are ethnic/racial minorities
- One in 12 Americans has Limited English proficiency issues
- Discrimination, bias and prejudice contribute to health care disparities
- Culturally responsive health care has many benefits
- Cultural competency is a core requirement of many national licensing and accreditation Bodies
- A few states have already mandated cultural competency training of healthcare providers (NJ, CA, WA)

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Benefits of Cultural Competence

(Betancourt et al., 2003; Brach and Fraser, 2002)

- Greater quality of provider-patient communication
- More successful patient education
- Increase in patient health-seeking behavior
- Increase in participation in preventive measures
- Greater adherence to treatment regimen
- Reduction in presentation to care for acute visits
- Better health outcome
- Fewer diagnostic errors

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Evidence for Clinical Benefits of Cultural Competence Not Yet Established

"Efforts to define culturally competent care are already in progress, but significant knowledge gaps exist about the direct relationship between cultural and linguistic competence and improved health outcomes."

National Quality Forum (NQF), October, 2007

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Study Design

- Partnered with three community-based hospitals serving medically underserved areas
- Developed an on-line survey for residents and teaching faculty
- Pilot tested the survey in Internal Medicine residency programs in the three participating hospitals
- Intend to conduct focus groups with teachers and housestaff to ascertain practices, perceptions and preferences on Cultural Competency Training (CCT)
- Implement a best practice cultural competency curriculum and evaluation based on the survey, literature and focus groups
- Follow patients' health indices with comparisons made before and after training

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Methodology

- Sampling
  - Convenience sampling of the three hospital residency programs in Internal Medicine
- Analysis
  - Descriptive Statistics initially (sub-groups too small)
  - Bi-variate and multi-variate analysis (Pearson chi-squares and Wilcoxon rank-order correlations of sub-groups to establish associations of responses with participant characteristics)

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The Survey

- Administered on-line (SurveyMonkey)
- Composed of:
  - Participant demographics
  - Assessment of existing cultural competency training
  - Measure of attitudes and perceptions related to cultural competency training (A four point Likert Scale)
  - Knowledge of national and state guideline pertaining to cultural competency

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Participants' Demographics
N=38

Category	Number	Percentage
Females	20	57.1
Asian	13	34.2
White (US born)	10	26.3
White (foreign-born)	6	15.8
Black	2	5.3
Hispanic	2	5.3
American Indian	1	2.6
Multicultural	1	2.6
Not disclosed	3	7.9
Total	**38**	**100**
Attending	2	5.3
Chief	1	2.6
Students	2	5.3
R-1	16	42.1
R-2	12	31.6
R-3	5	13.1

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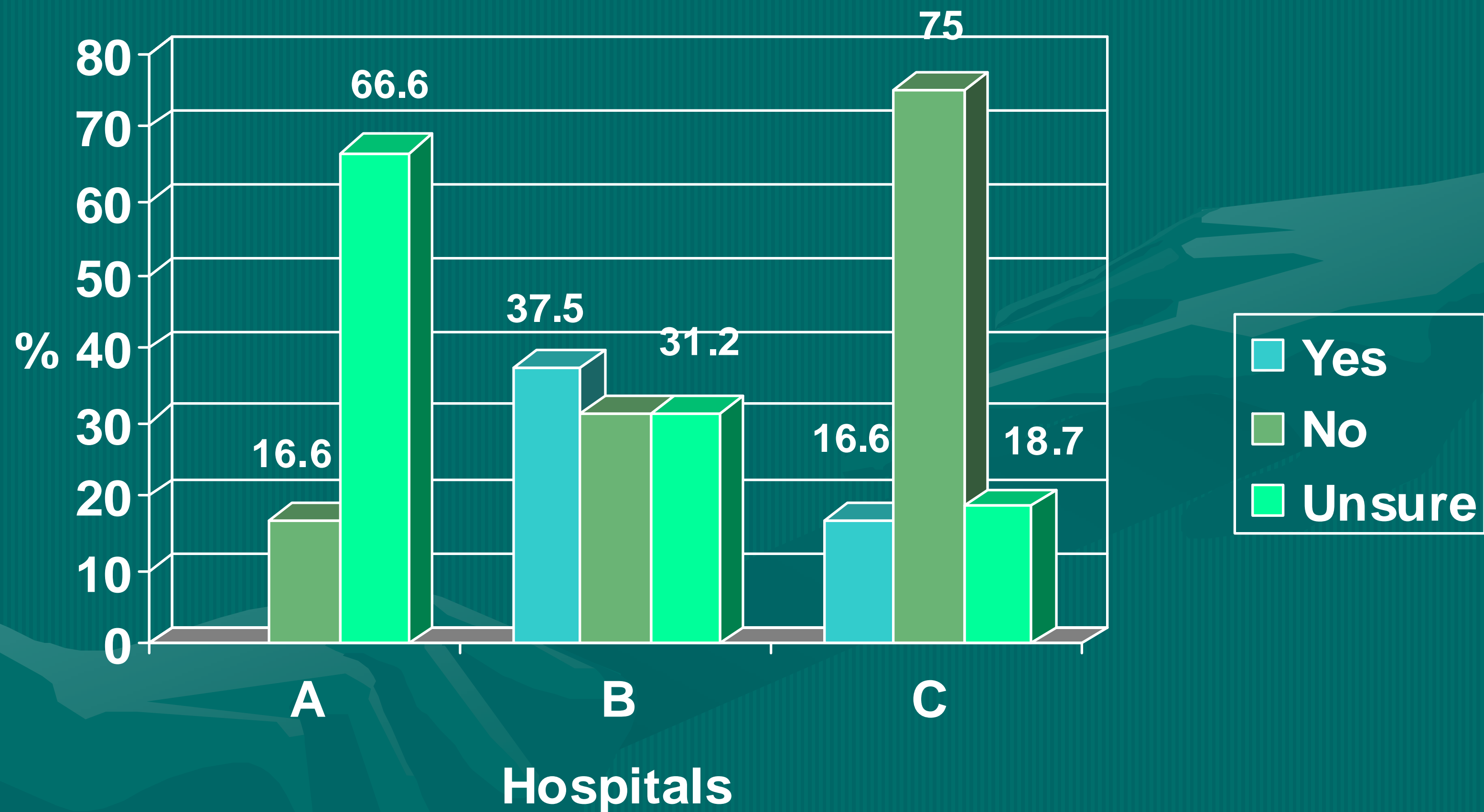
"Cultural competency training is mandatory in my hospital"



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Preliminary Results (n=38)

Item	Agree %
b. Cultural competency is important	100
c. CCT too difficult to implement in residency	18.4
d. CCT can improve providers cultural competency	100
e. I am satisfied with the existing CCT in my institution	65.8
f. There is evidence that CC enhances health outcome	89.5
g. CCT increases quality of care	100
h. CCT NOT important	5.3
i. Ethnic/racial concordance not important	34.2
j. Cultural competency should be acquired at home and can not be taught	5.3
k. On-line training is better for my schedule	50

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Reported Existing Training Style

Training Style	%
Web-based	33.3
Didactic	27.8
Workshops/seminars	25.0
Community Immersion	19.4
Grand rounds	13.9

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Preliminary Findings

- There is apparent confusion about requirements related to CCT in same institution
- The vast majority of respondents were unsure about licensing and accreditation bodies' regulations related to CCT
- There were no statistically significant differences between the responses of minority and non-minority respondents (gender and ethnic/racial backgrounds)

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Conclusions and Recommendations

- Medical residents in our survey population seem to agree with the importance of CCT and rejected the assertion that CCT is too difficult to apply in residency
- Uncertainty about institutional policies as well as national and state guidelines is evident
- Teaching faculty and residency directors must be clear about CCT requirements in the institution and external bodies

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