

Improving Patient-Provider Communication and Reducing Health Care Disparities by  
Increasing Patients' Health Care Cultural Literacy

Susana Peinado

Kaiser Permanente Cancer Communication Doctoral Fellows Seminar

Summer 2011

Eliminating racial and ethnic health disparities continues to be a challenge to health care organizations. Factors that lead to disparities in health and health care include social determinants and lack of health insurance or access to care (Betancourt, Green, & Carillo, 2002). However, racial and ethnic health disparities are not entirely explained by access to health care (AHRQ, 2009; IOM, 2003). Those who do have access to health care face other barriers. An Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, defined healthcare disparities as “racial or ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention” (2003, p. 4). Many studies have found disparities in health care associated with racial and ethnic differences. In reviewing the literature on disparities in health care, the IOM report found consistent and strong evidence of racial and ethnic disparities in many areas of medical care, as has a more recent report by the Agency for Healthcare Research and Quality (AHRQ, 2009).

Many factors contribute to health care disparities. Betancourt, Green, Carillo, and Ananeh-Firempong (2003) identified a range of barriers that contribute to disparities, including organizational, structural, and clinical barriers. Structural barriers to successfully navigating the health care system include language and literacy issues. In addition to structural barriers, clinical barriers come into play in interactions between patients and providers. These barriers are often related to culture and include variations in patients’ health beliefs and practices, attitudes toward medical care, levels of trust in doctors and the health care system, as well as participation in treatment decisions (Betancourt, Green, & Carillo, 2002; Betancourt, Green, Carillo, & Ananeh-Firempong, 2003; IOM, 2003). These factors can affect the quality of interpersonal relationships and communication between patients and providers.

An important potential contributor to health disparities is patient-provider communication and the patient-provider relationship (AHRQ, 2009). A lack of cultural sensitivity and patient-centeredness has been found to account for challenges in the relationship between patients and providers (Betancourt, Green, & Carillo, 2002). A study by Johnson, Roter, Powe, and Cooper (2004) that involved observing interactions during medical visits revealed that physicians were more verbally dominant and talked more with African American patients than with White patients. Physicians were also found to engage in less patient-centered communication with African American patients than with White patients. In addition, African American patients and their physicians exhibited lower levels of positive affect than White patients and their physicians. These findings provide support for the idea that improving patient-centered communication skills, along with cultural competency skills, will improve communication with racial and ethnic minority patients.

Other researchers interested in the role of the patient-physician interaction in explaining disparities in health care analyzed data from a nationally representative survey and found that the quality of patient-physician interactions was lower for minority patients, especially for Asian and Hispanic patients (Saha, Arbelaez, & Cooper, 2003). In particular, satisfaction with and use of health services were lower for Hispanics and Asians than for Blacks and Whites. Asians and Hispanics also reported lower levels of cultural sensitivity in their physician than other racial and ethnic groups. Researchers have also identified health literacy as having an influence on the quality of patient-physician interactions, satisfaction with health care, and the use of health services (Betancourt, Green, & Carillo, 2002; Saha, Arbelaez, & Cooper, 2003).

Interventions aimed at increasing cultural competence and patient-centered communication are often implemented in an effort to reduce health disparities. Training in

cultural competence and patient-centered communication may be a helpful way to reduce health disparities that result from ineffective patient-provider communication. Patient-provider communication is linked to patient satisfaction, adherence, and participation in decision making (Perloff et al., 2006). However, improving communication between patients and providers will likely involve more than simply requiring health care providers to attend training to increase their cultural competence and patient-centered communication skills. Because effective communication requires the active participation of both communicators, it will also be important to simultaneously target patients with materials or programs aimed at improving their communication skills and increasing their cultural competence in understanding and navigating the health care system.

Like other health care organizations, a critical objective of Kaiser Permanente is to improve the cultural competence of health care providers as well as the health care organization as whole. Kaiser is also working to increase minority membership in their health plan and satisfaction among current members with their health care experience. The goal of this paper is to review research and offer suggestions as to how to develop the most effective approach to achieving these objectives and improving health outcomes.

This paper presents research on cultural competence and its link with health care disparities, and suggests that provider training in patient-centered communication skills should be combined with any effort to increase cultural competence. I also present research and findings on interventions aimed at improving patient communication skills and propose that these kinds of programs along with an effort aimed at increasing patients' health care cultural literacy, or knowledge of the health care system and its culture, will be critical in achieving effective patient-

provider communication and relationships that will lead to a more satisfied and adherent patient membership as well as to a reduction in health care disparities.

### **Cultural Competence in Health Care**

Although evidence is scant due to limited research, there is reason to believe that cultural competency training can lead to improved communication between patients and providers as well as increased trust on the part of the patient, which could lead to better outcomes (Brach & Fraserirector, 2000). Providing culturally competent care improves the quality of care because it increases patient safety and the likelihood that patients will adhere to treatment (Office of Minority Health, 2002). Drawing from their own experiences as health care providers, Seibert, Stridh-Igo, and Zimmerman (2002) also suggested that cultural sensitivity and awareness can improve the recovery process for patients.

Most efforts to increase cultural competence at any or all levels of the health care organization are pursued in an effort to improve the quality of care for minority patients and to reduce disparities in health care. Brach and Fraserirector (2000) presented a model highlighting the link between cultural competency and the reduction of racial and ethnic disparities. She suggested that increasing cultural competency results in more appropriate and effective services for minority patients, which improves outcomes and therefore reduces disparities.

Cultural competence training may also be important because of the power imbalance in health care between doctors and patients (Office of Minority Health, 2002). This may in part account for the mistrust some minority patients have toward doctors and the health care system.

#### ***What is cultural competence?***

A culturally competent health care system is one that incorporates cultural competence at all levels of the health care delivery process (Betancourt, Green, Carillo, and Ananeh-Firempong,

2003; Office of Minority Health, 2002). This includes the organizational, structural, and clinical levels of care.

There are many definitions of cultural competence, as well as several alternative terms used to describe overlapping concepts, including cultural sensitivity and intercultural communication. Some definitions consider the meaning of cultural competence broadly, in terms of the entire health care organization. The definition proposed by the Office of Minority Health (2001) covers all levels of the health care process: system, organizational, and interpersonal. It 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” (p. ix).

Betancourt and colleagues consider cultural competence at the system level. Betancourt, Green, & Carillo (2002) defined cultural competence in health care as “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (p. v). Betancourt, Green, Carillo, and Ananeh-Firempong (2003) describe cultural competence in health care as “understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations” (p. 297).

Other definitions focus on cultural competence at the interpersonal level, between patients and health care providers, but also between any individuals who are working together in a health care environment. Some definitions describe a two-way interaction in which both

communicators are participants. According to Cooper and Roter (2003), “cultural competence may be defined as the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences” (p. 554). However, they also describe cultural competence at the patient-provider level “as a process in which the healthcare provider continuously strives to work effectively within the cultural context of a client” (p. 554). Seibert, Stridh-Igo, and Zimmerman (2002) define culturally competent health care in an interpersonal context as requiring “the health professional be sensitive to the differences between groups, to the differences in outward behavior, and also to the attitudes and meanings attached to emotional events such as depression, pain, and disability” (p. 143).

In their discussion of the importance of cultural sensitivity in interactions between patients and health care providers, Ulrey and Amason (2001) defined health care providers as anyone who works in a health care organization and comes in contact with patients, including front desk and administrative staff. They define cultural sensitivity in interpersonal interactions in health care as “a willingness to use cultural knowledge while interacting with patients and considering culture during discussions and recommendations for treatment” (p. 450).

Cultural competency is often rightly described as a process rather than an outcome (Campinha-Bacote, 2002; Perloff et al., 2006; The Joint Commission, 2010). Health care providers do not achieve cultural competence as a result of attending a training session and health care organizations do not achieve cultural competence simply as a result of offering training to their staff members. Campinha-Bacote (2002) presented a model of cultural competence in health care delivery. She conceptualized cultural competence as an ongoing process that involves cultural awareness (awareness of the influence of one’s own cultural and professional background), cultural knowledge (foundational knowledge of diverse cultural and

ethnic groups), cultural skill (the ability to collect relevant cultural information during a medical encounter and perform a culturally based physical assessment), cultural encounters (engaging in a variety of cross-cultural interactions with diverse others and assessment of patient's linguistic needs), and cultural desire (the motivation of the health care provider to want to increase their cultural competence and provide culturally competent care).

Brach and Fraserirector (2000) discussed a range of techniques for increasing cultural competence, such as providing interpreter services, recruitment and retention of minority staff, training programs, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family and/or community members, spending time immersed in another culture, and administrative and organizational accommodations.

This paper specifically focuses on cultural competence and health care disparities related to racial and ethnic minorities, but cultural competence can also apply to a range of other groups identified by social class, age, religion, health status (including individuals with disabilities), and health literacy skills, among others.

### ***Cultural competence in the patient-provider interaction***

Health care provider interventions to increase cultural competence tend to focus on increasing knowledge of different cultures and awareness of one's own culture and biases, as well as improving communication skills (Betancourt, Green, Carillo, and Ananeh-Firempong, 2003; Brach & Fraserirector, 2000; Cooper & Roter, 2003). Interventions also frequently address attitudes such as avoiding stereotyping (IOM, 2003; Office of Minority Health, 2002; Perloff et al., 2006).

Some researchers have developed checklists that health care providers can use to improve cultural competence in their interactions with patients. Seibert, Stridh-Igo, and Zimmerman (2002)

developed a checklist to facilitate cultural awareness and sensitivity in medical encounters. Their checklist contains ten items of which to be aware, including identifying barriers related to language and communication, identifying a patient's culture, checking comprehension, identifying beliefs, checking trust, checking views about recovery, addressing culture-specific dietary preferences, conducting culturally sensitive assessments, and being aware of biases.

The Joint Commission (2010) developed a checklist for hospitals to improve communication, cultural competence, and patient-centered care across the health care continuum. The checklist includes lists of action items related to admission, assessment, treatment, end-of-life care, discharge and transfer, and organization readiness. It emphasizes cultural competence and effective communication as a process that continues and changes over the span of care. The assessment, treatment, and discharge and transfer checklists cover considerations that would be important during patient-provider interactions, including being aware of health literacy issues, identifying a patient's specific cultural beliefs and practices that may influence their health care, involving patients and their families in the care process, providing education, and continually assessing communication needs. Checklist items that pertain to patient assessment include 1) identifying and addressing patient communication needs, 2) making introductions, 3) supporting the patient's ability to understand and act on health information, 4) identifying and addressing patient mobility needs, 5) identifying patient cultural, religious, or spiritual beliefs or practices that could affect care, 6) identifying patient dietary needs or restrictions, 7) asking the patient to identify a support person, and 8) sharing information about patient needs with the care team.

### ***Intervention evaluations***

Few studies have evaluated the effects of cultural competence interventions, and even fewer have evaluated the effects on health outcomes. Therefore, there is limited evidence for the

relationship between cultural competence and a reduction in health disparities (Perloff et al., 2006). Despite the lack of studies that test the impact of cultural competence interventions on health outcomes, cultural competence is still considered to be an important part of successful patient-provider communication, which is believed to have an effect on health care disparities (IOM, 2003).

There are many problems with evaluating the outcomes of cultural competency training. There is a lot of variety in the operationalization and implementation of cultural competency training programs. There is significant variation in terms of their length, focus, and frequency. This makes it difficult to compare programs and to determine which component of a program is responsible for positive effects.

A review of 34 studies evaluating cultural competence interventions by Beach et al. (2005) revealed that the interventions were effective in increasing knowledge and improving the attitudes and skills of health professionals. They also found evidence that interventions increased patient satisfaction. However, they found no studies that evaluated the effects of cultural competence interventions on health outcomes.

In investigating the effects of cultural competence interventions on health care providers, Ulrey and Amason (2001) found that as health care providers' intercultural communication effectiveness increased, their levels of anxiety decreased. A similar relationship was found between health care providers' cultural sensitivity and their levels of anxiety.

### **Cultural Competence and Patient-Centered Communication**

Culturally competent and patient-centered communication skills go hand-in-hand. According to Beach, Saha, and Cooper (2006), "patient-centeredness involves perceiving and evaluating health care from the patient's perspective and then adapting care to meet the needs

and expectations of patients” (p. iv). A patient-centered approach focuses on interpersonal relationships. A patient-centered approach is part of cultural competence, and cultural competence will increase patient-centeredness (Beach, Saha, & Cooper, 2006). Both approaches aim to improve health care quality. Together, they can lead to more effective communication in interactions between patients and health care providers (Beach, Saha, & Cooper, 2006; The Joint Commission, 2010).

A combined strategy that is both culturally sensitive and patient-centered will likely improve patient-provider communication and lead to increased trust by patients (Ulrey and Amason, 2001). For African American patients in particular, trust of white physicians is an important issue. However, there is not much to indicate how to increase trust other than engaging in more culturally sensitive, patient-centered communication (Perloff et al., 2006).

Communication between patients and physicians has been linked to important outcomes such as satisfaction with medical care, level of participation in decision making, and adherence to treatment (Perloff et al., 2006). Therefore, patient-centeredness may play a role in reducing health disparities because it focuses on increasing patient involvement in decision making and improving the relationship between the physician and patient. Cooper and Roter (2003) suggested a need for research on “the degree to which physicians’ cultural competence is explained by use of patient-centered communication” (p. 578).

Another important reason for combining cultural competence and patient-centered approaches is that training that addresses cultural differences can potentially lead to thinking in terms of stereotypes (Zarcadoolas, Pleasant, & Greer, 2006). Seibert, Stridh-Igo, and Zimmerman (2002) emphasized the importance of considering the role of cultural differences in patient-provider interactions, while taking care not to subscribe to the belief that everyone from a culture

is the same. Stereotypes can lead to expectations about patients and providers that can affect communication, including the amount of information delivered, the amount of supportive talk that occurs, as well as clinical performance (Cooper & Roter, 2003). A patient-centered approach addresses patients as individuals rather than as representatives of their cultural group or disease (Office of Minority Health, 2002). Therefore, as Beach, Saha, and Cooper (2006) argue, cultural competence efforts should be paired with efforts to increase patient-centeredness in order to avoid promoting stereotypes and assumptions about patients who are members of specific racial or ethnic groups.

### **Role of Patients**

Effective communication between patients and providers is a two-way process (The Joint Commission, 2010). Each participant brings his or her own cultural background and assumptions. Each participant also has normative expectations of the other's role in the interaction (Kreps & Kunimoto, 1994). This includes not only patients' expectations of physicians, but also others in health care organization, from the front desk to pharmacists. Patient expectations of roles and behaviors can become barriers to effective communication and interactions (Wohl, 1989).

Cooper and Roter (2003) emphasize "the reciprocal nature of the patient-physician relationship," pointing out not only the provider role, but also "the impact of patient expectations and judgments of physicians" (p. 578). Expectations and judgments go both ways. Race, ethnicity, and culture may not only affect the physician's beliefs about and expectations of patients, but can also clearly affect patients' beliefs about and expectations of physicians.

One way to address the role of patients in patient-provider communication is to target patients with communication skills training. Patient communication skills are an important part

of patient participation in the health care experience (Cegala & Post, 2006). Patients have an important role in the patient-provider relationship and patient-centered communication (Cegala & Post, 2006).

### ***Patient Education and Skills Training***

In a program that aims to improve cultural competence in patient-provider interactions, including a component that specifically addresses patients may increase its effectiveness. Communication will not be as effective if efforts are made to change only one side of a two-way interaction.

In addition to training programs for physicians, Betancourt, Green, & Carillo (2002) recommended improving clinical competence by including “programs to educate patients on how to navigate the health care system and become an active participant in their care” (p. x). Patient education and empowerment interventions can play a role in reducing health disparities (IOM, 2003). They can increase patient participation in clinical decision making. The IOM (2003) report on health care disparities recommends implementing culturally appropriate “patient education programs to increase patients’ knowledge of how to best access care and participate in treatment decisions” (p. 198). Patient education and empowerment programs typically include materials that provide guidance to patients about the clinical encounter, such as questions to ask.

Cooper and Roter (2003) also emphasized the benefit of coupling cultural competency training for physicians with programs aimed at increasing patient empowerment. They developed a model that proposes patient education and provider cultural competency training make important contributions to improving patient-provider communication and health-related outcomes. They suggested that “because strong evidence links these communication strategies [that increase patient empowerment] to improved patient outcomes, intervention studies that

target ethnic minority patients and incorporate communication skills training for physicians and empowerment strategies for patients should be conducted” (p. 580).

### *Interventions*

Interventions aimed at improving patient communication skills and increasing patient empowerment often address asking questions, providing information, expressing concerns, and articulating preferences (Cegala, 2006; Cegala & Post, 2006). Patient communication skills training interventions are typically evaluated by their effect on these communication behaviors (Cegala, McClure, Marinelli, & Post, 2000). Patient communication skills training may also have a positive effect on patient treatment adherence and health outcomes (Cegala, 2006). However, research that tests this connection is limited.

Cegala, McClure, Marinelli, and Post (2000) found that providing communication skills training to patients resulted in patients engaging in more information seeking, providing physicians with more information about the medical condition, and engaging in more verification of information received from physicians. Also, when patients were trained in communication skills, this resulted in a more patient-controlled style of conversation with physicians. Cegala, Street, and Clinch (2007) found that in interacting with patients who participated at a high level in the medical encounter, physicians provided them with more information in response to their questions, but also volunteered more information than when interacting with lower participation patients.

Cegala & Post (2006) investigated the influence of race and ethnicity on the effects of patient communication skills interventions. Their evaluation of an intervention designed to improve patient communication skills found the intervention had a significantly greater effect on participation skills for White compared to non-White patients, confirming other studies.

However, researchers have also suggested that interventions that include a face-to-face component may help in overcoming differential effects of interventions on minority and nonminority patients (e.g., Cegala, 2006).

An earlier study by Roter (1977) had some other alarming findings. This study found that a patient education program increased the number of direct questions asked by patients, but also resulted in more negative affect, anxiety, anger, and less satisfaction with care compared to patients who were not exposed to the education program. This could have occurred because patients' values and expectations were still not aligned with the information provided through the intervention. For example, an intervention may inform a patient that doctors do not always provide all the information the patient may need or want to know and therefore encourage the patient to seek information from his or her doctor by asking questions. Even if patients then follow up by asking more questions this does not mean they are satisfied with this new role they may feel is not appropriate. Patients may still feel that the doctor should provide this information without having to ask for it.

Reversing this attitude likely requires knowledge of the culture of health care, including clinical encounters and the roles of providers and patients. Patients often lack important cultural knowledge about normative expectations in health care interactions. Providing patients with education to improve their understanding of the culture of health care may be a way to better prepare patients and counteract any negative effects of pushing patients into a new role for which they would otherwise not be adequately prepared.

### ***Health Care Cultural Literacy: A Theoretical Approach***

Targeting patients (in addition to health care providers) with education and skills training programs will contribute to increasing health literacy, which in part includes the abilities to

communicate with health care providers and to navigate the health care system (Clancy, 2009; McCormack, 2009). According to the IOM, “while health literacy efforts are not limited to cross-cultural situations, and cultural competence efforts are broader than health literacy, initiatives in both these areas would benefit from coordination with each other” (2004, p. 113). Health literacy can also affect patients’ level of participation in their health care (Gruman et al., 2010).

When physicians and patients have different communication styles, which can often be culturally influenced, this can negatively affect the interaction (Perloff et al., 2006). Wohl (1989) suggested that all interactions between health care providers and patients are intercultural because the health care profession has its own culture with its own language, assumptions, and norms.

Zarcadoolas, Pleasant, and Greer (2006) provide a theoretical framework for understanding the role of patients beyond previous interventions to improve patient communication skills. Their model of health literacy encompasses skills in fundamental literacy, scientific literacy, civic literacy, and cultural literacy. Therefore, one domain of health literacy is cultural literacy. “Cultural literacy refers to abilities to recognize, understand, and use the collective beliefs, customs, worldview, and social identity of diverse individuals to interpret and act on information” (Zarcadoolas, Pleasant, and Greer, p. 57). They explain that “cultural literacy should be bilateral, in that the communicator (doctor, scientist, public health official) should understand aspects of the culture of the recipient (interlocutor), and the recipient should understand aspects of the professional culture of the sender” (p. 57). The concept of cultural literacy suggests that patients may not only need training in communication skills, but also in a type of cultural competence in order to increase their understanding of the culture of the health care system.

In order to tackle health disparities and achieve effective communication – communication that leads to treatment adherence, satisfaction, trust, and positive health outcomes – cultural competence, or cultural literacy, may also need to be approached from the patient side. Kelleher (2002) describes cultural literacy as “increased communicative access to the culture itself” (p. 497). Educating patients about the culture of health care organizations in which providers function – and in which patients must also function – will likely contribute to creating more culturally competent interactions on both sides as well as more effective communication.

Although Zarcadoolas, Pleasant, and Greer (2006) have introduced the concept of cultural literacy and the need to address culture from both sides of the patient-provider interaction, up to this point there does not seem to be much exploration of cultural literacy interventions aimed at patients. However, to have a truly culturally competent health care organization, of which patients are a part, it is necessary to address the cultural literacy (i.e., competence) of patients as well as providers. Developing interventions aimed at increasing patients’ health care cultural literacy would help to achieve this goal.

### **Future Research**

There is a need for more research that investigates the role of patient-provider communication in racial and ethnic disparities in health care (IOM, 2003; Cooper & Roter, 2003). Very limited research investigates the intersection between race and ethnicity and the effects of patient communication skills interventions (Cegala & Post, 2006). In addition, more research is needed on interventions that combine provider and patient communication skills (Cegala, 2006). There is a lack of investigation that directly links cultural competence, patient-centered communication, and patient communication skills training with health care delivery and

health outcomes (Betancourt, Green, Carillo, & Park, 2005; Fortier & Bishop, 2004). Finally, there exists essentially no research that investigates the effects of a combination of patient and provider cultural literacy and competence interventions on health and health care outcomes.

### **Proposal**

This paper proposes the need to address culture from both sides of the communicative relationship. It is clear from research that health literacy – including skills related to the ability to communicate and engage with health care professionals as well as understand and act on health information – plays an important role in the clinical encounter. In order to address the multiple factors that contribute to improving patient-provider communication and reducing health care disparities – including cultural competence, patient-centered communication, patient communication skills, and health and cultural literacy – it will be necessary to develop two-sided interventions (see Figure 1). These interventions would target both providers and patients.

Health care cultural literacy interventions may be particularly important for patients who are racial and ethnic minorities and who have a lower level of health literacy. Based on the finding that interventions designed to improve patient communication skills were not as effective for non-White patients (Cegala & Post, 2006), it may be particularly important to step back and provide these patients with some background information on the culture, norms, and role expectations that exist within the health care environment. These patients are also likely lower in health literacy, of which having some understanding of the culture of health care is part, so they may be less willing and able to make a smooth and rapid transition into the role of engaged patient. Like most interventions that take health literacy into account, even those with higher health literacy and who are information seekers may also benefit from this additional information.

Even those patients who do achieve a greater level of engagement in their health care as a result of a patient education program may not accept this new role and its related responsibilities. Recall the study by Roter (1977) that found patients who asked more questions following exposure to a patient education program also experienced more negative affect, anxiety, anger, and less satisfaction with care. In an attempt to avoid these negative effects, a health care cultural literacy program may help these patients to understand why this role they are being asked to take on is necessary and important and how it can result in improved care.

There are many barriers to such a multifaceted program, including costs, both financial and in terms of human resources. However, many health care organizations have already implemented programs aimed at increasing cultural competence. A patient-centered communication approach can be tied in with cultural competence training if it is not already. Tools for increasing patient communication, such as encouraging question asking, can easily be found online (<http://www.ahrq.gov/questions/>) or created. Adding a program that aims to increase the health care cultural literacy of patients would be the most challenging component, especially since few if any such programs currently exist.

Developing an effective health care cultural literacy program for patients would involve determining what a patient needs to know to understand the culture of the health care system and to function successfully within in it in order to achieve the best health outcomes. Health care cultural literacy materials for patients may take a page from cultural literacy programs in fields outside of health care. They may simply start by providing an explanation of the roles and expectations of health care providers and patients. They may emphasize the team aspect of health care, how patients and providers need to work together to achieve the best outcomes. They may need to provide patients with some new vocabulary that they may frequently encounter in the

health care environment. They may include stories, charts, music, videos, games, maps, images, or other visual aids to enhance understanding. It is also important to regularly send materials to reinforce new skills and continue the acquisition of new knowledge and skills (Hassett, 2005).

Once implemented, it would be important to evaluate this program, particularly the patient health care cultural literacy component in terms of whether it results in:

- Improved health outcomes
- Increased patient satisfaction
- Higher patient ratings of physicians
- Increased minority patient membership
- Increased or maintained cost-effectiveness

Answering the above research questions would make an important contribution to the literature and theory surrounding provider cultural competence and patient health care cultural literacy and their potential role in improving patient-provider communication and reducing racial and ethnic disparities in health care.

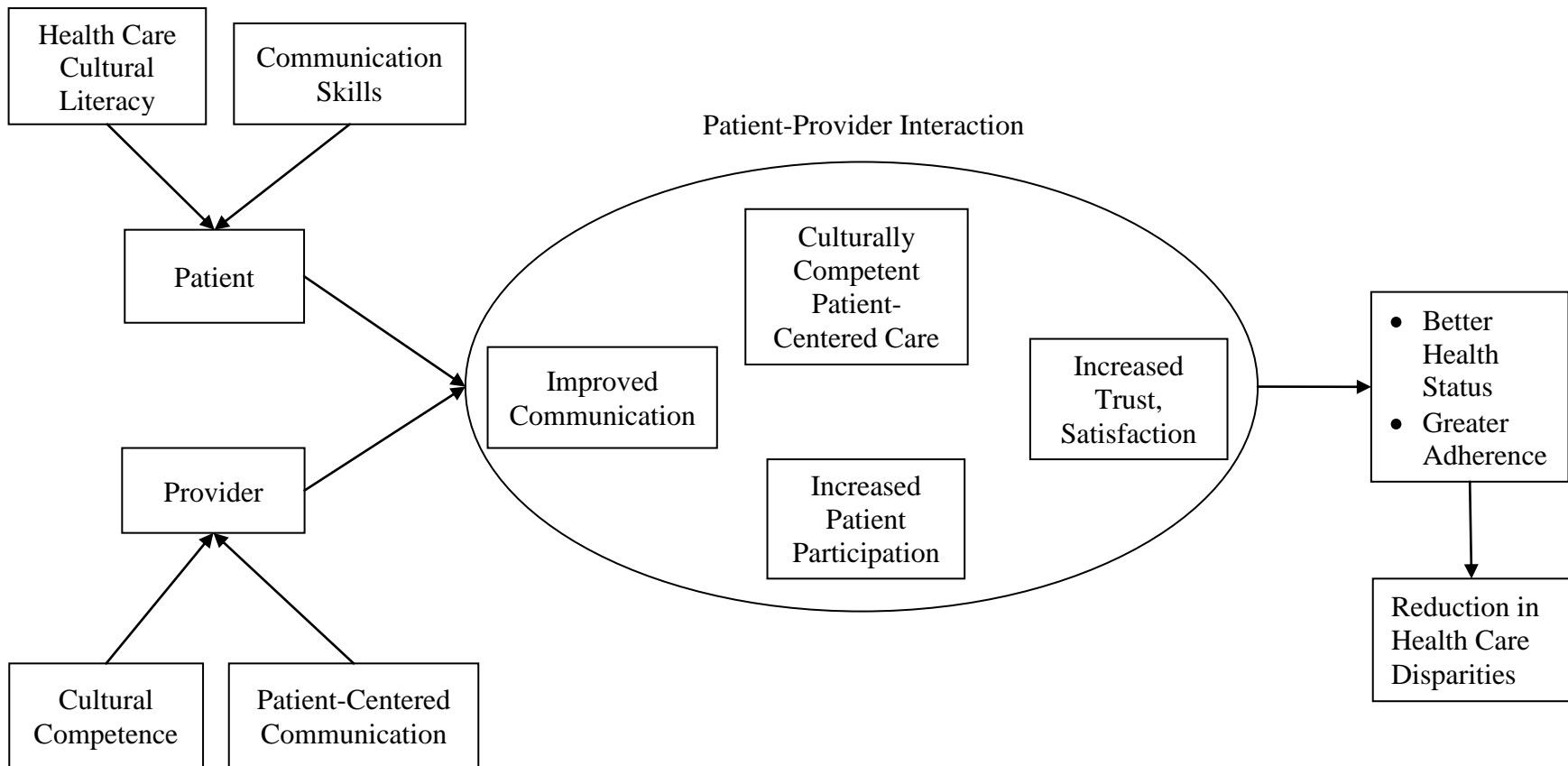
## References

- Agency for Healthcare Research and Quality (AHRQ). (2009). *National healthcare disparities report* (AHRQ Publication No. 10-0004). Retrieved from <http://www.ahrq.gov/qual/qdr09.htm>
- Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., ... Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care*, *43*(4), 356-373.
- Beach, M. C., Saha, S., & Cooper, L. A. (2006). *The role and relationship of cultural competence and patient-centeredness in health care quality*. New York, NY: The Commonwealth Fund.
- Betancourt, J. R., Green, A. R., & Carillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. New York, NY: The Commonwealth Fund.
- Betancourt, J. R., Green, A. R., Carillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*, 293-302.
- Betancourt, J. R., Green, A. R., Carillo, J. E., & Park, E. R. (2002). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, *24*(2), 499-505.
- Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, *57*(Supplement 1), 181-217.
- Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, *13*(3), 181-184.

- Cegala, D. J. (2006). Emerging trends and future directions in patient communication skills training. *Health Communication, 20*(2), 123-129.
- Cegala, D. J., McClure, L., Marinelli, T. M., & Post, D. M. (2000). The effects of communication skills training on patients' participation during medical interviews. *Patient Education and Counseling, 41*, 209-222.
- Cegala, D. J., & Post, D. M. (2006). On addressing racial and ethnic health disparities: The potential role of patient communication skills interventions. *American Behavioral Scientist, 49*, 853-867.
- Cegala, D. J., Street, R. L., & Clinch, C. R. (2007). The impact of patient participation on physicians' information provision during a primary care medical interview. *Health Communication, 21*(2), 177-185.
- Clancy, C. (2009). Health literacy measurement: Mapping the terrain. In *Measures of health literacy: Workshop summary* (pp. 5-11). Washington, DC: The National Academies Press.
- Cooper, L. A., & Roter, D. L. (2003). Patient-provider communication: The effect of race and ethnicity on process and outcomes in health care. In B. D. Smedley, A. Y. Stith, & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in healthcare* (pp. 552-593). Washington, DC: The National Academies Press.
- Fortier J. P., & Bishop, D. (2004). *Setting the agenda for research on cultural competence in health care: Final report*. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality.
- Gruman, J., Rovner, M. H., French, M. E., Jeffress, D., Sofaer, S., Shaller, D., & Prager, D. J. (2010). From patient education to patient engagement: Implications for the field of

- patient education. *Patient Education and Counseling*, 78, 350-356.
- Hassett, P. (2005). Taking on racial and ethnic disparities in health care: The experience at Aetna. *Health Affairs*, 24(2), 417-420.
- Institute of Medicine (IOM). (2003). *Unequal treatment: Confronting racial and ethnic disparities in healthcare*. Washington, DC: The National Academies Press.
- Institute of Medicine (IOM). (2004). *Health literacy: A prescription to end confusion*. Washington, DC: The National Academies Press.
- Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health*, 94(12), 2084-2090.
- Kelleher, J. (2002). Cultural literacy and health. *Epidemiology*, 13(5), 497-500.
- Kreps, G. L., & Kunimoto, E. N. (1994). *Effective communication in multicultural health care settings*. Thousand Oaks, CA: Sage Publications.
- McCormack, L. (2009). What is health literacy and how do we measure it? In *Measures of health literacy: Workshop summary* (pp. 29-34). Washington, DC: The National Academies Press.
- Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf>
- Office of Minority Health. (2002). *Teaching cultural competence in health care: A review of current concepts, policies and practices*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/1/em01garcia1.pdf>
- Perloff, R. M., Bonder, B., Ray, G. B., Ray, E. B., & Siminoff, L. A. (2006). Doctor-Patient

- Communication, Cultural Competence, and Minority Health: Theoretical and Empirical Perspectives. *American Behavioral Scientist* 49(6), 835-852.
- Roter, D. L. (1977). Patient Participation in the Patient-Provider Interaction: The Effects of Patient Question Asking on the Quality of Interaction, Satisfaction and Compliance. *Health Education & Behavior*, 5(4), 281-315.
- Saha, S., Arbelaeq, J. J., & Cooper, L. A. (2003). Patient-Physician Relationships and Racial Disparities in the Quality of Health Care. *American Journal of Public Health*, 93(10), 1713-1719.
- Seibert, P. S., Stridh-Igo, P., & Zimmerman, C. G. (2002). A checklist to facilitate cultural awareness and sensitivity. *Journal of Medical Ethics*, 28, 143-146.
- The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Oakbrook Terrace, IL: The Joint Commission.
- Uray, K. L., & Amason, P. (2001). Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. *Health Communication*, 13(4), 449-463.
- Wohl, J. (1989). Integration of cultural awareness into psychotherapy. *American Journal of Psychotherapy*, 43(3), 343-55.
- Zarcadoolas, C., Pleasant, A. F., & Greer, D. S. (2006). *Advancing health literacy: A framework for understanding and action*. San Francisco, CA: Jossey-Bass.



*Figure 1.* This model shows the role of patient and provider skills in developing effective patient-provider interactions to reduce health care disparities among racial and ethnic minority patients.