

Culturally Competent Care

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In 1900, 88% of the U.S. population was composed of white people. Minorities, including African Americans and Hispanics, lived in certain parts of the country but were barely found in others. We had, in other words, a fairly homogeneous nation.

More than 100 years later, the demographic landscape of the nation is dramatically different. According to the 2010 Census, the percentage of white people is now approximately 72%. Of the 300 million people who live in the United States, more than 100 million are classified as minority, including, among other groups, African American, Hispanic or Latino, Native American, Asian, and Middle Eastern (U.S. Census Bureau, 2010). Decade after decade, immigrants have made possible our nation's rich diversity.

THE CURRENT STATE OF HEALTHCARE DISPARITIES

In the healthcare setting, these demographics have very real and personal implications. Data show that medical outcomes are routinely better for whites than for minority populations, especially with respect to certain disease conditions, such as heart disease, cancer, HIV, and diabetes. For instance, African American women and men ages 45–74 years had the largest death rates from heart disease and stroke in 2006 compared to men and women of other racial and ethnic groups (Office of Minority Health, 2011). These *health* disparities speak to differences among population groups in the incidence, prevalence, and outcomes of health conditions. *Healthcare* disparities, meanwhile, refer to the inferior quality of and accessibility to healthcare experienced by minority groups (MLibrary, 2013).

The Agency for Healthcare Research and Quality (AHRQ, 2011) states in its report on healthcare disparities that “All Americans should have equal access to high-quality care. Instead, we find that racial and ethnic minorities and poor people often face more barriers to care and receive poorer quality of care when they can get it.” Specifically, AHRQ found that blacks received worse care than whites for 41% of quality measures studied (e.g., pneumonia, surgery, influenza, heart failure). Asians received worse care for 30% of measures, and Hispanics for 39% of measures. Poor people of all racial/ethnic categories, meanwhile, received worse care for 47% of measures.

THE CHALLENGE AND OPPORTUNITY

These facts are intolerable. For Catholic healthcare, disparities present a challenge and an opportunity—a challenge to reduce, or eliminate altogether, healthcare

inequality and an opportunity to provide consistently high-quality care regardless of the patient's ethnic background.

The mission of Catholic healthcare is profound but simple: to treat with dignity and compassion every person who is in our care. This means preventing or healing illness but also being sensitive to the cultural preferences and needs of our patients. Addressing healthcare disparities is core to our mission—every person is created in God's image, and we must respect and understand the differences in how patients perceive their caregivers, the system, and medicine and recovery in general.

As noted by Thies (2010, pp. 11–12), "The very mission of Catholic healthcare draws us to emphasize the importance of culturally competent and linguistically appropriate care as we bring together people of diverse backgrounds and answer God's call."

Many Catholic health systems and hospitals actively work on programs and outreach strategies to reduce or eliminate healthcare disparities in their communities. This vital work includes cultural competency efforts to align the unique needs and perspectives of our patients with caregivers' communication processes and treatment regimens.

In 2007, for example, Providence Center for Health Care Ethics, in Portland, Oregon, developed a competency curriculum for physicians that covers three key areas: disclosing a serious diagnosis and prognosis to people from different cultures, discussing code status, and introducing transition to hospice.

In researching the Center's curriculum, Segal and Hodges (2012, p. 32) found that "Culture plays a key role in health care and particularly in palliative care because it influences how we understand autonomy, and it plays a significant role in defining how patients and families make meaning out of illness and suffering, expressions of pain, expectations about care, hopes for the future and views regarding death."

Imagine for a moment what it would be like to be sick or physically compromised and not be able to communicate with your caregivers—to not understand what they are saying or to become greatly alarmed when you hear information in terms that are offensive or inappropriate in your culture.

Quality care depends on quality communication. According to a 2002 study by The Joint Commission, more than 65% of sentinel events (unexpected deaths or serious physical or psychological injuries) were the result of hospital communication problems (Runy, 2008, p. 1).

For these reasons (and for the benefit of caregivers, too, who need to understand what the patient is saying), language interpreters can make a major difference. More than 10 years ago, Mercy Medical Center in Des Moines, Iowa, hired a fluent Spanish speaker to be its first staff interpreter. He started in a "tiny broom closet with a folding chair" (Thomson, 2010, p. 30) but by 2010 headed a staff of 22 full- and part-time interpreters speaking Spanish, Bosnian, Arabic, and American Sign Language.

Mercy Medical Center staff and others who work on this issue in Catholic healthcare widely agree that "whatever the price of using health care interpreters, the price of not using them can be exponentially higher" (Thomson, 2010, p. 32).

In addition to the excellent work being performed by Catholic Health Association (CHA) members across the United States, we focus on the issue here at the association, too. In 2011, we joined the Equity of Care coalition (www.equityofcare.org), which launched a national call to action to eliminate healthcare disparities and improve quality of care. As part of the work, the organizations involved, including CHA, the American College of Healthcare Executives, the American Hospital Association, the Association of American Medical Colleges, and the National Association of Public Hospitals and Health Systems, are collaborating on national-level improvement efforts, such as those aimed at providing hospitals, clinicians, and educators the tools they need to ensure equity of care is achieved.

CONCLUSION

Making progress on healthcare disparities is about equality, fairness, and the fundamental dignity of each person, regardless of her country of origin or the language she speaks. This issue is about both patients and caregivers—who also carry cultural expectations and may not always understand patients' behaviors or reactions to procedures.

I encourage healthcare leaders across the country to take a close look at this issue at your facility and in your community. Tremendous resources are available to help identify needs and collect data, draft a plan, implement quality improvements and culturally sensitive care models, and monitor the impact of these efforts over time.

The Affordable Care Act (ACA) has moved U.S. healthcare closer to becoming a system that serves everyone. Addressing healthcare disparities is a crucial part of implementing the ACA and creating the just healthcare system our nation needs and deserves.

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