

Two-Year Evaluation Report of the Cultural Competency Curriculum Modules (CCCMs)

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Contract #263-01-0046
Task Order #C-2348

February 9, 2007

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Executive Summary

Significant research documents the existence of racial and ethnic disparities in health. For example, the *2005 National Healthcare Disparities Report* finds that while some disparities are diminishing, health disparities continue to exist “across all dimensions of quality of healthcare” (AHRQ, 2005).

In December 2000, the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services released the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) to address inequities that exist in the provision of health services and to provide a framework for common understanding and guidance regarding cultural competence in healthcare. OMH then commissioned the development of the Cultural Competency Curriculum Modules (CCCMs) as a tool to help physicians develop the competencies required to improve the quality of care for ethnically diverse communities.

The present report offers findings of a two-year evaluation of the CCCMs’ impact on physicians’ knowledge, attitudes, and skills in the provision of culturally competent care. A repeated measures design was used to examine changes between before- and after-curriculum knowledge of cultural competency. As a means to capture the most comprehensive picture possible of curriculum efficacy, a concurrent mixed-methods approach incorporated qualitative data from focus groups, questionnaires, and open-ended questions.

2,213 physicians who participated in the curriculum between December 2004 and December 2006 were included in this study. Quantitative data find that although physicians appear to enter the CCCMs with a reasonable understanding of cultural competency, curriculum participation is consistent with meaningful score increases on cultural competency knowledge tests. Overall, we find effect sizes to be large and above 0.90 on average.

Qualitative results offer evidence that curriculum participation renders a positive impact on practice behavior. Physicians mentioned that as a result of taking the course, they attempted to be more cognizant and sensitive to cultural differences, took more time with patients, and asked more patient-centered questions. Our analyses further reveal that after curriculum participation, physicians express sympathy for diverse patients whose clinical encounters have been negatively impacted by cultural or language barriers. There is also strong evidence that curriculum participation results in enhanced self-awareness of cultural competency concepts.

While these are suggestive results, the CCCMs’ ultimate impact on patient care and the potential to reduce health disparities hinges on the degree to which physicians translate knowledge into behavior change in the clinical environment. Limitations of this study include the use of physician self-report data and concerns as to whether knowledge tests accurately capture physicians’ practice behavior. Recommendations for further enhancing the evidence base for this program include: experimental designs establishing treatment and control groups, incorporating patient perspectives of their physicians’ cultural competency via surveys, and the incorporation of health outcomes data to identify a potential link between cultural competency education and a reduction in health disparities.

Background and Purpose

Overview

A significant body of research documents the existence of racial and ethnic disparities in health care. The seminal 2002 Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* found significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. Other research has shown that cultural and language gaps between providers and patients can lead to a substandard level of care (Andrulis, Goodman, and Pryor, 2002). The *2005 National Health Care Disparities Report* finds that while some disparities are diminishing, health disparities continue to exist “across all dimensions of quality of health care” (AHRQ, 2005, p. 2). Satcher and colleagues estimate that 83,570 deaths each year could be prevented in the United States if disparities in the black-white mortality gap could be eliminated (2005).

As the United States becomes increasingly diverse, confronting and eliminating health disparities grows more urgent. In response to these disparities and the growth of minority and immigrant populations in the United States, a number of national and State-level initiatives have been initiated to improve the health and health care of minority and other underserved populations. For example, the Federal public health agenda, *Healthy People 2010*, establishes the elimination of health disparities as one of its two overarching goals (DHHS, 2000).

Thom et al. state that “increasing the cultural competence of physicians and other health care providers has been suggested as one mechanism for reducing health disparities by improving the quality of care across racial/ethnic groups” (2006). Most recently, some states including New Jersey and Washington have passed legislation requiring cultural competency education as part of physician licensure or as a requirement for health professions education (New Jersey S411, 2005; Washington 6194, 2006).

In December 2000, the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services released the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) to address inequities that currently exist in the provision of health services and to provide a framework for common understanding and guidance regarding cultural competence in health care. The CLAS standards are organized by three themes: *Culturally Competent Care, Language Access Services, and Organizational Supports*.

OMH commissioned the development of the Cultural Competency Curriculum Modules as a tool to equip physicians with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities. The curriculum is grounded in the principles of the CLAS standards and is structured around their three themes.

Curriculum Theme One, *Culturally Competent Care*, provides physicians with an overview of health disparities and cultural competency, describes the developmental nature of cultural competency, and offers tools and strategies for patient-centered care and effective communication.

Curriculum Theme Two, *Language Access Services*, illustrates the importance of language access services, offers models for providing them, and articulates strategies and suggestions for working effectively with medical interpreters.

Organizational Supports, the third theme, articulates the importance of organizational environment and climate in ensuring cultural competency, offers strategies for assessing the service community, and provides resources and tools for building community partnerships as a means to enhance care.

This report is a two-year evaluation of the Cultural Competency Curriculum Modules' impact on physicians' knowledge, attitudes, and skills in the provision of culturally competent health care. This evaluation addresses the following research questions:

Does completion of the curriculum result in physicians':

- (1) increased knowledge of culturally competent care models, principles, and theories as measured by pre- and post-curriculum knowledge tests?
- (2) change in attitudes toward diverse patient types?
- (3) change in use of interpreter services and translated materials?
- (4) improved practice habits?
- (5) enhanced educational/communication practices in direct physician-patient interactions (i.e., clinical encounters without medical interpreters)?

This effort represents a first step in the evaluation of this educational program. In the future, explorations of patient-report data and/or indicators for health outcomes may contribute to a further understanding of the potential impact of the intervention on the reduction of health disparities.

Cultural Competency Curriculum Modules (CCCMs): Education Intervention Description

The purpose of this curriculum is to help physicians develop the competencies required to improve the quality of care for ethnically diverse communities.

The curriculum has the following learning objectives:

- Define issues related to cultural competency in medical practice.
- Identify strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that may influence clinical care.
- Devise strategies to enhance skills toward the provision of care in a culturally competent clinical practice.
- Demonstrate the advantages of the adoption of the CLAS standards in clinical practice.

The CCCMs were developed over a period of three years and four months and were continuing education accredited and launched on the Web on December 6, 2004, available at <http://www.thinkculturalhealth.org>. The curriculum development evolved through several stages. The first step included a review of literature related to cultural competence and analysis of theories, research, and instructional strategies to be employed in the curriculum modules. The literature

review covered three areas: research pertaining to cultural competence, cultural competence curricula currently used in different domains of health care, and documents from State and local agencies that address cultural competence across appropriate programs. Findings were synthesized to create an Environmental Scan which served to guide a Consensus-Building process and the first meeting of the National Project Advisory Committee.

A National Project Advisory Committee (NPAC) was convened to serve in an advisory capacity during the curriculum development process. NPAC members provided guidance throughout the development stage of the project.

A Consensus-Building meeting was held as a means of establishing priorities for the Cultural Competency Curriculum Modules. Additionally, it was important for the credibility and comprehensiveness of the curriculum that the perspectives, concerns, and knowledge of various stakeholder groups were reflected in how the modules were developed, presented, and written. Concept papers focusing on the three themes of the CLAS standards facilitated discussion at the Consensus-Building meeting and helped to identify potential focus areas for the design of the modules.

The Cultural Competency Curriculum Modules underwent two phases of testing by physicians across the country. Five sites were used to conduct pilot testing, and seven sites were used to complete the field testing phase of the module development process. Participating physicians were asked to complete the modules and respond to a set of curriculum evaluations; in-depth group interviews were then conducted with physicians using a standardized protocol. Data from evaluation forms and interviews were synthesized to create recommendations for revisions that were put forth to the NPAC and Office of Minority Health. In order to ensure that feedback was balanced and would result in a curriculum that was adaptable to a diverse audience of physicians, pilot and field sites were geographically distributed throughout the nation and included sites in rural, urban, and suburban areas; additionally, physicians were chosen with an eye toward diversity in ethnic and racial background, as well as age and years of experience.

The curriculum structure enables learners to integrate awareness, knowledge, and skills into culturally competent practices (Figure 1).

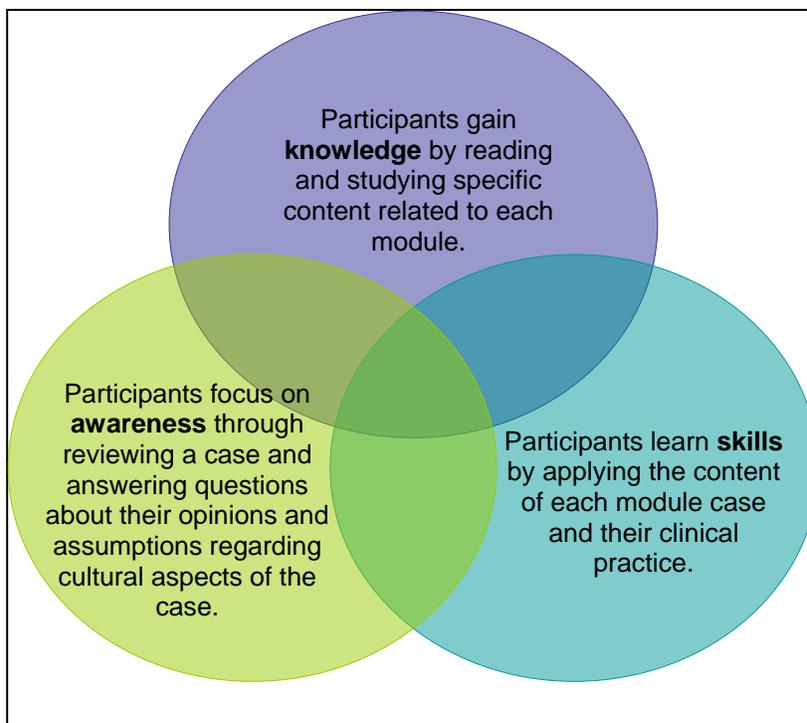


Figure 1: Integration of awareness, knowledge, and skills

The CCCMs are a Web-based curriculum organized by the three themes of the CLAS standards. Each theme is further divided into three modules. Each module starts with a pretest that is intended to measure participants' existing knowledge of relevant concepts, identify knowledge gaps, and focus participants' attention on specific concepts discussed in the module.

In terms of instructional content, each module is organized around a video-enabled case study that illustrates the concepts covered in course material. Using video as a semantically rich media type enhances instructional message and focuses the learner's attention not only on the concepts covered in the module, but also on the non-verbal communication cues that are very important for effective inter-cultural communication.

Module case studies are based on a fictional family practice office that is a composite of several real locations. Participants of the case studies include two family physicians, a resident in osteopathic medicine, a Physician Assistant, an RN, and a receptionist that staff the medical practice. One of the family physicians speaks Spanish fluently. The situations depicted in the case studies reflect the real-life situations that physicians face as they interact with ethnically diverse populations.

After viewing each case study, physicians answer self-exploration questions designed to stimulate in-depth reflection of their feelings related to the learning content. The questions also encourage relating the case study to their own experiences involving cultural competency concepts. Case studies were developed by an instructional designer, reviewed by the NPAC which included cultural competency experts, educators, and physicians, and were pilot and field tested with

physicians across the country. Case study videos range from three to twelve minutes in length; users can read a narrative version of the case study and/or review the streaming video vignette. Self-exploration questions follow the pattern of a modified BATHE medical interviewing technique (Stuart and Lieberman, 2002)¹. After completing self-exploration questions, participants review instructional content and have an opportunity to transfer their knowledge to solving problems related to their own clinical experiences. They can also compare their own insights to those submitted by their peers. A module posttest consisting of ten multiple choice questions concludes each module (pre and posttests are provided in Appendix C). Items were developed by an instructional designer and posttest questions sampled from the pretest. Test questions were reviewed by the NPAC as well as the accrediting agency that certifies the program for continuing education credit.

To enrich the learning experience, the curriculum includes “Fast Facts” which offer statistics, resources, and snapshots of best practices in culturally competent care. “Take a Moment” questions are interactive “quick-polls” that enable users to respond to questions about their practice and view real-time statistics of how other physicians responded.

The curriculum is designed for self-study, and participants can complete the course in several sessions by using their secure username and password to re-enter the site.

The cultural competency curriculum modules were initially targeted for an audience of family physicians. Family physicians were selected as the primary population for this curriculum because of the wide diversity of patients they serve and their “gatekeeper” role in the health care system. Case studies focused on conditions OMH has identified as priorities for eliminating health disparities, including: cancer, cardiovascular disease, and diabetes. Other pervasive conditions addressed in the CCCMs include asthma and obesity.

After the December 2004 launch of the curriculum, a large volume of feedback was received from a range of professionals in the health care community about their interest in completing this curriculum. As a result of interest from other provider types, accreditation for the course was expanded to nurses and pharmacists. However, the curriculum was not revised for these audiences. The Cultural Competency Curriculum Modules remain a physician-focused curriculum.

Nearly a third of physicians participating in this curriculum heard about the program from their State’s Quality Improvement Organization (QIO). The QIOs promote and implement quality improvement initiatives of the Centers for Medicare and Medicaid Services and the OMH curriculum was selected as the “program of choice” for their initiative to reduce health disparities.

¹ The BATHE communication model is a mnemonic designed to elicit the psychosocial context of a patient’s condition and/or why they are seeking care. This model guides providers through questions pertaining to the background, affect, trouble, and handling of a health issue and then has the provider express empathy as a means to provide support to the patient (Stuart and Lieberman, 2002). Other communication techniques covered in the curriculum include: Kleinman’s explanatory model (1980), LEARN (Berlin and Fowkes, 1983), ETHNIC (Levin, Like, and Gottlieb, 2000), ESFT (Carrillo et al, 1999), and Sunrise (Leininger, 1978).

Almost 20% of physicians report hearing about this educational program from colleagues. Other avenues through which physicians hear about the CCCMs include: e-mail, printed program announcements, search engines, residency programs and medical school assignments, other web sites and conferences.

Because the CCCMs are a free Web-based curriculum, no geographical or institutional barriers prevent physicians from taking this course. However, internet access is required to participate in the curriculum. Participants come from all parts of the United States; a number of users also participate from overseas.

Methods

Overview

The purpose of this concurrent mixed methods study is to explore the impact of the Cultural Competency Curriculum Modules on physicians' knowledge, attitudes, and skills in providing culturally competent care by converging both quantitative and qualitative data. In concurrent procedures, quantitative and qualitative data are collected at the same time and both forms of data are integrated into the interpretation of overall results. An alternative method would have been sequential design, whereby findings from one type of analysis (i.e., qualitative or quantitative) are expanded upon by adding another form of data. (CITE) A concurrent methodology was used because the program remained available to users during this entire period and allowed us to capture data from a large sample over time, and allowed for the recruitment of physicians for focus groups over a span of time. Physician recruitment is often time-intensive because of the demanding schedules of health care providers.

In this study, a repeated measures design is used to examine changes between before- and after-curriculum knowledge of cultural competency. Qualitative data from focus groups, questionnaires, and free text/open-ended questions supplement quantitative data. The rationale for using both types of data is to provide a comprehensive analysis of the research problem and to document nuanced constructs such as provider attitudes and physician self-awareness.

The present evaluation uses physicians (MDs and DOs) as the primary study group because the curriculum was initially conceived and designed for this population. During the two-year study period of December 6, 2004 to December 5, 2006, 2,255 physicians registered for the cultural competency course.

6,964 total subjects registered for the curriculum in the two years following accreditation and launch. Of this total, 32.38% (n=2,255) were physicians. 46.52% (n=1,049) physicians completed at least one curriculum theme.

Program registration data indicate that users practice in a variety of settings, including: hospitals, clinics, private practice, community health centers, nursing homes, and other settings. Although

participants have a wide range of practice specialties, the most common specialties are: family practice, internal medicine, and pediatrics.

As compared to the national physician population, females are disproportionately participating in the CCCM program (Table 1). While females comprise 27.15% of the U.S. physician population, females make up 41.80% of the physician population completing at least one curriculum theme. Females are more likely than males to specialize in family medicine (11.16% as compared to 8.26%), and this may contribute to the disproportionate participation of females in the curriculum because the CCCMs were initially targeted for family physicians (AMA, 2006). Additionally, research shows greater sensitivity of females to issues related to cultural diversity (Mohapatra, 1994).

It is difficult to make direct comparisons of the race/ethnicity of the national physician population and our study sample for a number of reasons. First, race/ethnicity is unknown for nearly 40% of the national population as reported by the American Medical Association (AMA) (see Table 2). Second, the AMA does not collect data for the specific category of Native Hawaiians and other Pacific Islanders. What we can say is that whites make up the largest racial/ethnic group in both the national physician population and our study sample.

Gender	National Physician Population* (Number)	National Physician Population* (Percent)	Study Sample (Number)	Study Sample (Percent)
Male	657,140	72.85%	1,288	58.20%
Female	244,913	27.15%	925	41.80%

Ethnicity	National Physician Population* (Number)	National Physician Population* (Percent)	Study Sample (Number)	Study Sample (Percent)
White, non-Hispanic	419,110	46.46%	1,353	61.27%
Hispanic	27,929	3.10%	167	7.55%
Black	20,667	2.29%	233	10.53%
Asian	73,054	8.10%	296	13.38%
American Indian or Alaska Native	509	0.06%	14	0.63%
Native Hawaiian or other Pacific Islander	--	--	14	0.63%
Other	20,013	2.22%	133	6.01%
Unknown	340,771	37.78%	--	--

*Source for National Figures: *Physician Characteristics and Distribution in the US*. 2007 Edition (December 2006). American Medical Association.

Tables 1-2: Characteristics of the National Physician Population and Study Sample

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Data sources for this evaluation are both quantitative and qualitative and include: pre-and posttest scores captured by the program database, physician responses to open-ended self-exploration questions about case study scenarios, qualitative data from focus groups, and results from a questionnaire distributed to focus group participants.

Quantitative Methods

Quantitative exploratory analyses included standard statistical techniques for assessing frequencies, outliers, normality, and attrition.

Because we restricted our sample to physicians who completed at least one curriculum theme, it may appear that there was no program attrition. However, we do note here that a sizable number of users who register for the program do not complete at least one theme. Among all registrants, 40.92% completed at least one theme, and this number is higher among physicians at 46.52%. Future efforts could help explore why participation drops off before completion, but likely explanations derived from user feedback are length of the course and respondent fatigue.

Two population breaks were explored for quantitative pre- and posttest score data. The first was physician race/ethnicity; the second was physician affiliation with a Quality Improvement Organization (QIO). QIOs are entities in each state that promote and implement quality improvement initiatives of the Centers for Medicare and Medicaid Services. This population break is included to examine potential differences in treatment. While non-QIO physicians are self-selecting participation in the cultural competency course, QIO-affiliated physicians are being recruited by their State organizations to take part in the curriculum. These participants may receive a higher intensity of treatment. Prior to taking the course, QIO physicians complete a CLAS standards pre-assessment exercise, receive ongoing communications from their state QIO, and in some cases receive additional support to promote culturally competent care. Hence, it can be argued that QIO physicians receive a qualitatively different educational treatment than non-QIO physicians. 50.56% of physicians in our population are affiliated with a QIO (n=1,119).

For race/ethnicity, white physicians were separated from minority physicians for the purposes of these analyses; in the context of promoting cultural issues, it seems reasonable to consider these groups as somewhat independent. A number of studies have pointed to patient-provider racial concordance as a contributor to health outcomes and perceptions of care. Studies among adults suggest that patient-provider racial concordance is associated with higher satisfaction and partnership with physicians (Stevens, Shi, and Cooper, 2003). In 2003, Saha et al. conclude that barriers in the patient-physician relationship contribute to racial disparities in the experience of health care. Furthermore, in the context of psychology, researchers indicate that members of a majority culture tend to be less cognizant of cultural impacts and this holds true with service providers (Sue, Bingham, Porche-Burke, & Vasquez, 1999).

These population breaks were used to construct eight separate pre-post analyses:

- QIO minority and nonQIO minority
- QIO white and nonQIO white

- QIO minority and QIO white
- nonQIO minority and nonQIO white

All four quantitative hypotheses above will take on the general form of:

$H_0: \mu_B = \mu_A$

$H_A: \mu_B \neq \mu_A$

Where:

The subscripts B and A represent the before-and after-participation conditions.

H_0 refers to the null hypothesis, or a hypothesis of no difference. This posits that there is no relationship between the independent variable (curriculum participation) and the dependent variable (change in cultural competency knowledge), as measured by mean pre and posttest scores. H_A is the alternative hypothesis – the one to be considered if we reject the null. The alternative hypothesis suggests, in essence, that two groups formed by virtue of the impact of the CCCMs. To clarify, these are repeated measures analyses with no control group because all physicians in our study population completed at least one themes of the curriculum.

We note here again that the evaluation report provides eight dependent (i.e., repeated measures) t-tests, two for each of the above groups. The tests were based on the difference between pretest scores and grand mean posttest difference (i.e., the average of posttests 1, 2, and 3). This was done to address a slightly unconventional data structure where each posttest is dependent and there is no meaningful time element in the design. That is, the evaluation did not focus on the timing of each posttest because they measured slightly different elements of the knowledge construct but there was no effort in the present work to consider knowledge maintenance over time. Given these circumstances, it was reasonable to limit tests of null hypothesis significance testing to aggregate differences since no information via trend analyses would be lost. This approach, meanwhile, provides an overview of whether there are statistically significant differences between knowledge on the pretest score and the average knowledge exhibited across three posttests. This approach also provides some protection against elevated family-wise experimenter error rates (i.e., increased Type 1 error). This was decided on an a priori basis since the evaluators also planned to use the Bonferonni correction.

Of course, questions of statistical significance in this context have limited meaning since each of these tests was very well-powered; even very small differences could be detected. To supplement our inferences, effect sizes were estimated via unstandardized mean differences (i.e., simple difference between pre- and posttests), and calculating standardized mean gains (i.e., difference scores divided by the pre and posttest pooled standard deviation; see Lipsey & Wilson, 2001). The first metric provides a simple difference score and is readily interpretable. The second metric standardizes this difference to make it easier to compare the effect of the curriculum to other efforts to educate professionals on cultural competency. All difference scores divided by its estimates of variability “standardizes” the difference, putting it on a universal scale. Hence, if another professional development curriculum uses a very different measure, we can still compare impacts.

Qualitative Methods

Two types of qualitative data were used in this evaluation: focus group results and physician open-ended responses to self-exploration questions. Eight focus groups were conducted between March 2, 2005 and May 23, 2006 using a standardized Moderator's Guide. Focus groups were conducted in the following locations: Baltimore, Maryland; Columbia, South Carolina; Oklahoma City, Oklahoma; Omaha, Nebraska; Santa Fe, New Mexico; Seattle, Washington; Sea-Tac, Washington; and Winston-Salem, North Carolina. The Baltimore and Santa Fe sites were academic health settings. An anonymous questionnaire of ten items was distributed at the end of each focus group to collect additional information.

Self-exploration questions elicit physicians' reactions to curriculum case studies, and responses are a required curriculum component (i.e., physicians must provide responses to these questions as they proceed through the course). Two self-reflection questions were selected for analysis of evaluation objective two which explores the extent to which completion of the curriculum results in physicians' change in attitudes toward diverse patient types. Physician responses were isolated from those of non-physician participants in the data set and a coding protocol applied (Appendix A).

Due to limited resources, full data sets were single-coded rather than double-coded. To ascertain interrater reliability, 50 randomly selected responses for each question were blind double-coded by two individuals. Intercoder training was then performed to enhance reliability and then a second test was performed. Interrater reliability for the first question was .94 and .90 for the second question. (Details of the agreement rate are supplied in Appendix B). To ensure reliability throughout the coding process, comparisons of results were made every 100 observations.

For focus group data, reports from individual focus groups were reviewed and relevant findings were mapped to the evaluation objectives. Focus group remarks pertaining to perceived program impact were also highlighted even if they did not map directly onto an evaluation objective. Relevant findings were grouped by objective (or theme) and then assessed for patterns and range of responses within the objective. When available, supplementary focus group questionnaire results were included and coupled with narrative findings and comparisons made.

Results

Objective 1: Explore the extent to which completion of the curriculum results in physicians' increased knowledge of culturally competent care models, principles, and theories.

Quantitative results demonstrate that physicians score higher on CCCM posttests than on pretests, and this difference is statistically significant. Although statistical significance may be driven by our

large sample size, our analyses in total suggest that curriculum participation tends to result in knowledge gains as reflected by pre- and posttest scores.

It is likely that the most intuitive column in Tables 2-6 is the ones showing a mean difference. This is simply the posttest scores minus the pretest. It is noteworthy that all of the comparisons show a positive increase, ranging from 1.01 to 2.01. In a case where the mean difference is about two, then the physicians increased their scores by about two points on average after completing a curriculum module. These increases occur in a context where there is a possible ceiling effect because the scales range only from 0-10, and physicians tended to score in the seven range on pretest scores. Put another way, the data indicate physicians entered the CCCMs with a reasonable understanding of cultural factors in practice, given the outcome measures. The pretest standard deviations suggest these scores were somewhat tightly packed, as they ranged from 7.30 to 7.52. This means the majority of the physicians did not score much differently from the mean values presented.

We can see in Tables 2-6 that posttest scores are high and ranged from 8.35 for Theme 2, to 9.37 for Theme 3.

Outcome Measure by Group	Pretest X	Pretest SD	Posttest X	Posttest SD	Pooled SD	Mean Difference	Effect Size	p-Value
Posttest 1	7.34	1.58	8.52	1.20	1.40	1.18	0.84	
Posttest 2	7.34	1.58	8.35	1.46	1.52	1.01	0.66	
Posttest 3	7.34	1.58	9.24	1.07	1.35	1.90	1.41	
X Posttest-Pretest	7.34	1.58	8.7	1.24	1.42	1.36	0.96	p<.01

Table 3: Population Comparisons for Non-QIO Minority (N=289)

Outcome Measure by Group	Pretest X	Pretest SD	Posttest X	Posttest SD	Pooled SD	Mean Difference	Effect Size	p-Value
Posttest 1	7.33	1.65	8.42	1.29	1.48	1.09	0.74	
Posttest 2	7.33	1.65	8.46	1.42	1.54	1.13	0.73	
Posttest 3	7.33	1.65	9.25	1.04	1.38	1.92	1.39	
X Posttest-Pretest	7.33	1.65	8.71	1.25	1.46	1.38	0.94	p<.01

Table 4: Population Comparisons for QIO Minority (N=455)

Outcome Measure by Group	Pretest X	Pretest SD	Posttest X	Posttest SD	Pooled SD	Mean Difference	Effect Size	p-Value
Posttest 1	7.30	1.54	8.67	1.10	1.34	1.37	1.02	
Posttest 2	7.30	1.54	8.55	1.31	1.43	1.25	0.87	
Posttest 3	7.30	1.54	9.31	1.00	1.30	2.01	1.55	
X Posttest-Pretest	7.30	1.54	8.84	1.14	1.35	1.54	1.14	p<.01

Table 5: Population Comparisons for Non-QIO White (n=528)

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Outcome Measure by Group	Pretest X	Pretest SD	Posttest X	Posttest SD	Pooled SD	Mean Difference	Effect Size	p-Value
Posttest 1	7.52	1.53	8.69	1.15	1.35	1.17	0.86	
Posttest 2	7.52	1.53	8.70	1.38	1.46	1.18	0.81	
Posttest 3	7.52	1.53	9.37	1.04	1.31	1.85	1.41	
X Posttest-Pretest	7.52	1.53	8.92	1.19	1.37	1.4	1.02	p<.01

Table 6: Population Comparisons for QIO White (N=889)

Despite large pretest scores, these data show consistent and meaningful increases in the outcome measures, as indicated by the large standardized effect sizes. As mentioned above, this metric divides the difference scores by their pooled standard deviation, which makes the outcome comparable to other interventions that endeavor to show knowledge gains.² Cohen (1988) suggested that small, medium, and large effect sizes might correspond with values of .20, .40 and .80; Lipsey & Wilson (2001) provided some empirical support for this suggestion. A review of the above tables shows, that by these criteria, all of the effect sizes can be construed as large.

Effect size is a way to quantify the difference between two groups. Since we do not have a control in this design, groups are derived from pre-curriculum test scores and post-curriculum test scores. In the case of an effect size of 0.8, the average posttest score exceeds the scores of 79% of the pretests. For an effect size of 1.4, the average posttest score exceeds the scores of 92% of the pretests. In our results tables above, effect sizes range from 0.66 to 1.55.

Again, the fact that statistically significant differences were found between pretest scores and an average posttest score is not surprising given the sample sizes and above effect sizes.

We initially set out to test whether QIO-affiliated physicians may have experienced a differential treatment effect because they were recruited by their State organizations and may have received more reminders and support in completing the curriculum than their self-selecting counterparts who are not QIO-affiliated. We found no evidence of a QIO treatment effect. We also explored whether there were any differences between white physician and minority physician performance on test scores after completing the curriculum. Again, we found no effect. Hence, these groups could be combined and there would be no important changes to the pattern of results presented here. The more aggregated groups would still show gains ranging between scoring about one to two items from pre to posttest.

It is also important to reiterate that our sample was limited to physicians who completed at least one curriculum theme and thus, it may appear that there was no program attrition. In reality, only

² Lipsey & Wilson (2001) warn that the standardized mean gain is not comparable to effect sizes based on between group contrasts (i.e., treatment and comparison group differences). This is because the gain score approach allows each person to serve as his or her own control. This is different interpretation than one makes using more common effect sizes. Furthermore, the variance in the denominator may be somewhat lower because individuals serve as their own control, and a smaller denominator may yield larger standardized effect sizes. For this reason, the standardized gain score is readily comparable to ones derived from studies that also lack control groups, but caution should be used when making any other comparison.

46.52% of physicians who register for the CCCM complete at least one theme. There may be unobservable characteristics between completing and non-completing physicians that make extrapolations of our results to all physicians tenuous. For example, completing physicians may have more time, interest, and willingness to learn about cultural competency than their non-completing counterparts and therefore may be more open to behavior change or may put more effort into this educational activity.

Objective 2: Explore the extent to which completion of the curriculum results in physicians' change in attitudes toward diverse patient types.

To assess the degree to which completion of the curriculum results in physicians' change in attitudes toward diverse patient types, responses to two self-exploration questions were coded using a standardized protocol (Appendix A). Self-exploration questions are free-text/open-ended items that physicians complete after viewing case study scenarios designed to elicit their insights into cultural competency concepts.

The first case study describes a scenario where Mrs. Williams, an American Indian patient with diabetes seeks care from her family physician, Dr. Brown. The patient tells her doctor about the traditional therapies she has been using which she believes are making her feel better. However, the physician insists that she needs to be admitted to the hospital for medical tests even though the patient is fearful of the hospital. In this scenario, the patient and physician are unable to negotiate a treatment plan.

After viewing the case study, physicians completed the following reflection question: "*How do you feel about the situation? Do you feel sympathy for either Mrs. Williams or Dr. Brown?*" Physician responses were coded to assess attitudes toward Mrs. Williams, the American Indian diabetes patient (Figure 2).

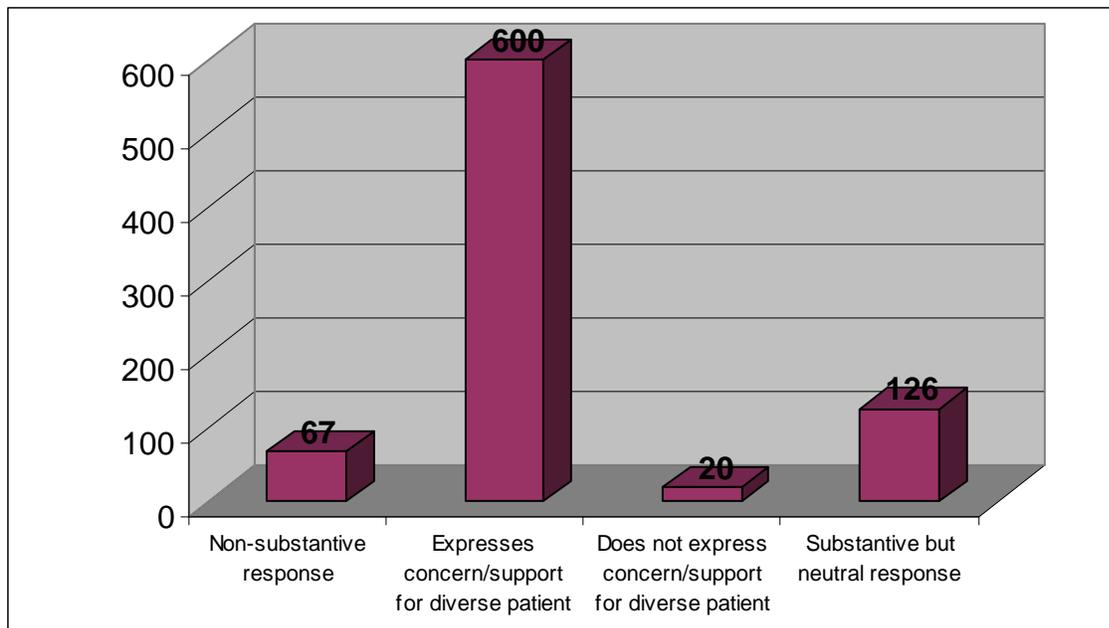


Figure 2: Physician attitudes toward diverse patient, case one

The overwhelming majority of physician responses, 73.8%, expressed sympathy for the patient and concern about the care she received from Dr. Brown. A number of physicians felt that Dr. Brown failed to provide adequate education about diabetes, and many others suggested that Dr. Brown should have tried to blend traditional and Western treatment plans. Responses also indicated that physicians did not feel Dr. Brown tried hard enough to understand his patient’s fears and concerns. Examples of physician responses include:

I feel a lot of sympathy for Mrs. Williams. She is afraid of the hospital because of her experiences there and she is looking for comfort and healing from her family as well as from her physician. I believe Dr. Brown means well, but he comes across as arrogant and uncaring. He sees Mrs. Williams' disease, but he does not see her. He is condescending and rude. He will not be able to help her until he meets her where she is at. People don't care what you know until they know that you care.

I feel sympathy for both because they are both losing out. Mrs. Williams isn't receiving the necessary care she needs and Dr. Brown is getting frustrated with the patient and may consciously or unconsciously begin to deliver substandard care thus contributing further to the disparities in health care for this patient and her ethnic group. The way he treats this patient, I believe, will definitely impact whether or not other members of her ethnic group seek care from him versus traditional medicine healers.

A small number of physician responses, less than 3%, expressed negative attitudes or a lack of support for the patient, Mrs. Williams. Examples of negative remarks included:

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No I don't feel sympathetic for Mrs. Williams. I think if you go to a professional you should listen to his advice. I do feel bad for the Dr. because there is only so much he can do.

I feel more sympathy towards Dr. Brown because he is attempting to treat her diabetes according to standard of care and EBM, but his lack of sympathy is well-noted. Although I don't know the entire life of Mrs. Williams, it's hard to feel sympathy for her when she has not taken care of herself and seems to avoid the severity of her diabetes. Her approach to treat diabetes with traditional medicine is well-intended, but it may be too little, too late.

Overall, both the frequency and range of responses for this self-exploration question support the finding that course participation appears to have promoted cultural sensitivity as reflected by physicians' expression of support and concern for diverse patient types.

The second case study used for this research question involves an encounter at the office front desk where Mrs. Gonzalez, an LEP patient who comes into the office agitated and upset, asks to see the doctor without an appointment. After considerable chaos, Mrs. Gonzalez is able to see her physician, but not before the receptionist loudly remarks, "If you live in America, you should speak English. There should be a law!"

For a self-reflection exercise, participants were asked "What troubles you the most? Do you have a greater concern with the office and its staff, or with the patient?" Physician responses were coded to assess attitudes toward Mrs. Gonzalez, the diverse patient in this scenario.

Results of this coding are provided in Figure 3.

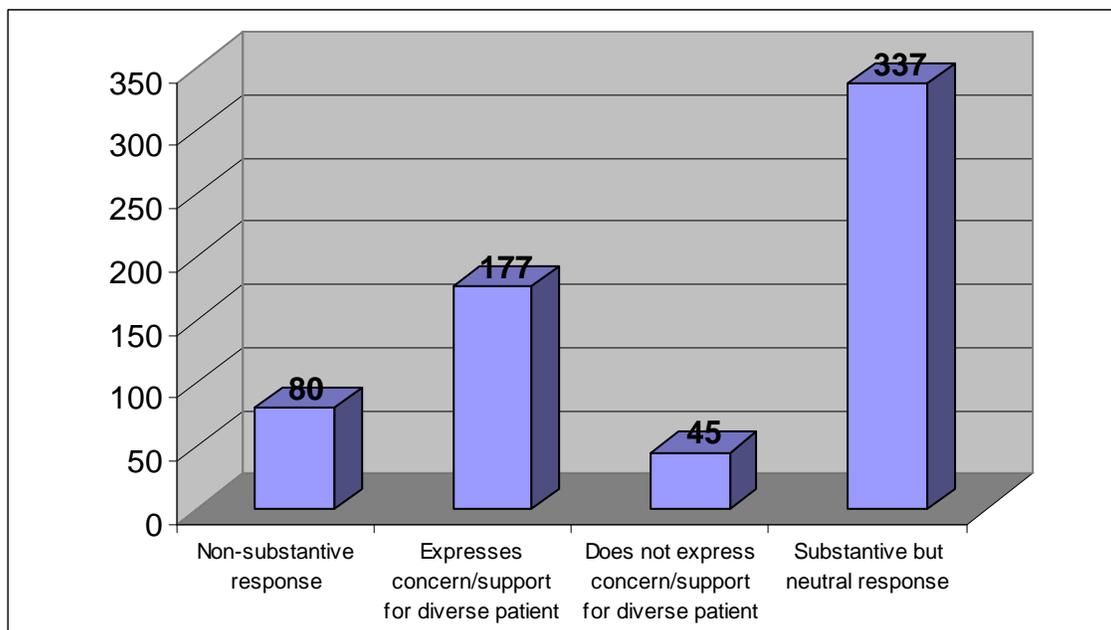


Figure 3: Physician attitudes toward diverse patient, case two

27.7% of physician responses directly expressed support for the patient and were concerned about the quality of care she received. A number of physicians felt that the office staff behaved inappropriately and caused a barrier to good patient care that could deter patients from seeking care in the future. Several physicians felt that such a situation would increase the risk of poor health outcomes. Two examples of responses that express concern for Mrs. Gonzalez include:

While individuals who plan long-term residency in an English speaking country should make some attempt to be able to function within that context, this won't always result in people who are functional in English. Therefore the front desk staff (as well as the clinicians) should be looking for ways to decrease the barriers to good care including language / cultural accommodations. I am concerned that the attitude portrayed here indicates that the office is office-centered, not patient-centered.

The office staff are providing very substandard care by their underlying stereotyping. If someone who was non-English speaking was seriously ill, this could be a very serious situation with increased risk for poor outcomes.

7.04% of physician responses felt that the office staff was at least partially in the right. Several physicians agreed with the receptionist that the patient should be speaking English. One physician stated:

It can be difficult to work with patients like these; they often have very little insight into the problems, often come in very emotional and in crisis, and can be difficult to help. It is very difficult to try to work with our system; the appointment style doesn't work well, i.e. if they feel fine they don't come, they are often late given the cultural

differences with time management, transportation can be a problem, etc. Both the staff and the patients are fighting an uphill battle. I see both sides.

Over half of physician responses were neutral to the patient or were substantive but did not directly answer the question about their concerns with the scenario. A sizable portion of responses were very short, such as “both” or “office and patient.” The lack of details in such physician responses made it difficult to categorize answers as obviously supporting only the patient or office staff. During interceder training, it was determined these responses would be coded as neutral because they were substantive from the perspective that they made sense in the context of the case study, but did not provide enough information to clearly designate to whom the learners’ sympathy and concern was directed. This result suggests that this exploration question may need to be rewritten to more fully engage the learner in self-reflection.

12.52% of physician responses were non-substantive.

Objective 3: Explore the extent to which completion of the curriculum appears to result in physicians’ change in use of interpreter services and translated materials.

None of the focus group participants indicated that they decided to use an interpreter or provide translated materials as a direct result of being exposed to this curriculum. However, there is evidence that the course raised physician’s awareness about techniques they were using with medical interpreters. Physicians stated that as a result of completing the curriculum they recognized the potentially negative implications of using family members as interpreters and began to assess whether interpreters were qualified to be in that role. One physician stated: *“One thing that impacted me was not using family members as interpreters. A lot of times I’m forced to do that or it seems like the best method at the time, but now I can understand how certain issues may be sensitive to people, even if I don’t think they are sensitive issues.”*

One physician specifically identified that the curriculum helped him to understand the business case for providing language access services. He stated: *“I really started to realize that having an interpreter is a good practice builder. It has been a boon to my practice.”* Another doctor stated that he now interacts with interpreters differently and is aware of the utility of “pre-sessions” to clarify expectations for the medical interview. He stated: *“I learned a lot about dealing with interpreters. Recently, I had an interpreter who just took off talking to the patient because I did not tell him I wanted to be in charge of the conversation. Now I am a lot more in-tune and aware.”*

To the extent that curriculum participation could initiate more effective use of interpreters and improve communication when there are language barriers, then the ability of the physician and patient to more fully understand each other may be enhanced. By raising physician’s awareness of the benefits of using trained interpreters and techniques of working with interpreters, the curriculum may stimulate positive change in patient health outcomes. Taken together with quantitative evidence that curriculum participation increases physician knowledge of cultural

competency concepts, and that effect sizes are large, there is emerging evidence that the CCCMs are a promising educational intervention.

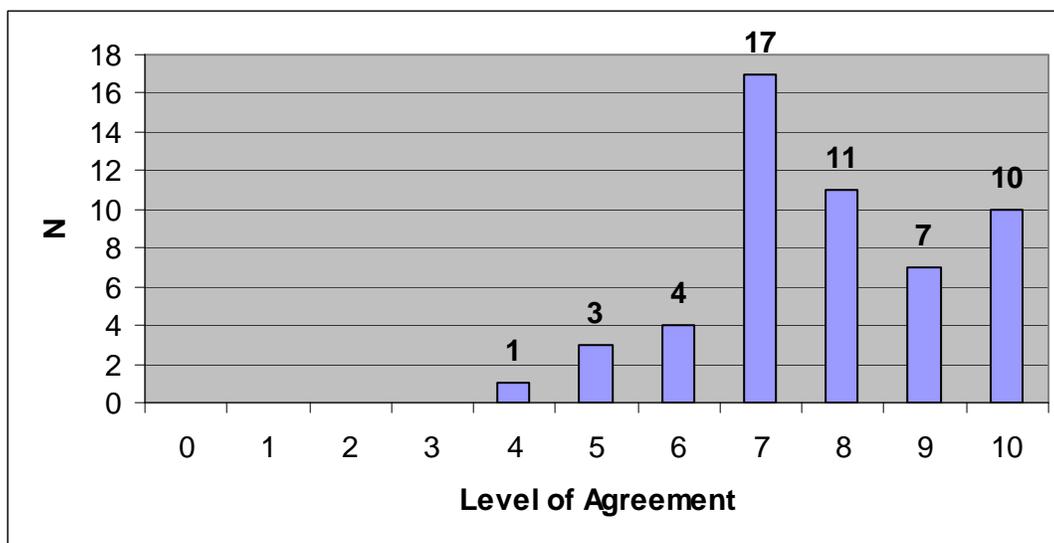
Objective 4: Explore the extent to which completion of the curriculum results in physicians' improved practice habits.

Focus group physicians reported a variety of changes to their practice habits during focus groups that were a result of their curriculum participation. The following changes were mentioned: attempting to be more cognizant of cultural differences, taking more time with patients, asking more questions of patients, and collection of more thorough past histories during the clinical encounter.

One physician stated: *“It made me more aware of the cultural differences. It has caused me to take a little more time with patients when I know there is a language or cultural difference. That is a positive change that has remained. I’ve remained more sensitive about patient-centered care and started asking my patients: ‘What do you think we should do about this?’”*

Focus groups did not capture the frequency or magnitude with which physicians were changing practice habits. However, responses were captured for the following questionnaire item; “Since completing the Cultural Competency Curriculum Modules, I believe I have actually changed my practice habits to reflect what I learned in the course.” Participants were asked to rate their level of agreement with the statement from 0 – 10 (10 being high).

The mean response for this question was 7.8, indicating that physicians tend to agree that the curriculum has stimulated behavior change (Figure 4). This measure and verbal comments collected during focus groups are consistent. However, participants may self-report a higher degree of behavior change than actually transpired. Physician observation or patient surveys would be methods to confirm self-report data.



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Figure 4: User responses to focus group questionnaire item, “Since completing the Cultural Competency Curriculum Modules, I believe I have actually changed my practice habits to reflect what I learned in the course” (N=53)

The mean number of days elapsed between completion of a curriculum theme and focus group participation was compared to determine if there were any trends in the persistence of self-reported effect (i.e., do physicians self-report a greater degree of behavior change the more recently they have completed the curriculum). There does not appear to be a strong association between these two measures (Table 7). A larger sample size and/or additional self-reflection questions would be needed to more fully examine this relationship.

Date	Mean Days Elapsed	Average Score: “Since completing the CCCMs, I believe I have actually changed my practice habits to reflect what I learned.” (Scale: 0-10; 10 high)
March 2, 2005	6.5	5.6
July 19, 2006	13.9	8.1
February 11, 2006	15.6	8.3
February 9, 2006	23.6	8.3
August 24, 2006	31.3	7.4
May 4, 2006	82.0	7.3
March 29, 2006	109.4	7.9
May 23, 2006	131.6	6.7

Table 7: Mean Days Elapsed and Self-Reported Behavior Change

Objective 5: Explore the extent to which completion of the curriculum results in physicians’ enhanced educational/communication practices in direct physician-patient interactions (i.e., clinical encounters without medical interpreters).

Course content pertaining to certain communication practices were new to many participants, which suggests that the curriculum may have the potential to influence physician behavior if concepts are applied in clinical practice. In particular, communication models such as the BATHE medical interviewing technique were cited as tools physicians were previously unaware of.

Some physicians stated that they printed out communication models presented in the curriculum and intended to use them in direct patient interactions; others stated they had shared or would share the tools with their colleagues. Two examples of specific applications of communication techniques offered in the curriculum were provided:

I had a young patient who was assaulted and came to me with headaches and there was a lot of negotiation of what was really going on. BATHE helped elicit what the situation really was.

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I remember a young patient who had a new diagnosis of genital herpes and using BATHE really helped me understand what she was going through. At first I would have thought it was just a huge emotional outburst, but I used the model to elicit more of what was really going on.

Physicians participating in focus groups did not offer specific examples of applying communication models with negative results; however, several providers indicated reluctance to use these models and/or caution about their application. One representative remark included:

Kleinman’s explanatory model provides a good guideline for what questions you might want to ask in unique cultural encounters. But it doesn’t always work, sometimes people ‘trip up’ and the patient-physician encounter becomes awkward. It should be used as a guide, not verbatim. It could be cumbersome if relied on too much.

The positive examples happened to be offered only by medical residents who had less clinical experience. Further research could help to explore whether physicians with less clinical experience are more likely to implement concepts presented in the curriculum as compared to more seasoned physicians.

When asked whether focus group participants agreed with the statement: “I have applied at least one of the culturally competent communication techniques that I saw in the vignettes in my daily practice,” the mean was 7.62, suggesting that physicians implemented communication techniques from the modules to some extent (Figure 5).

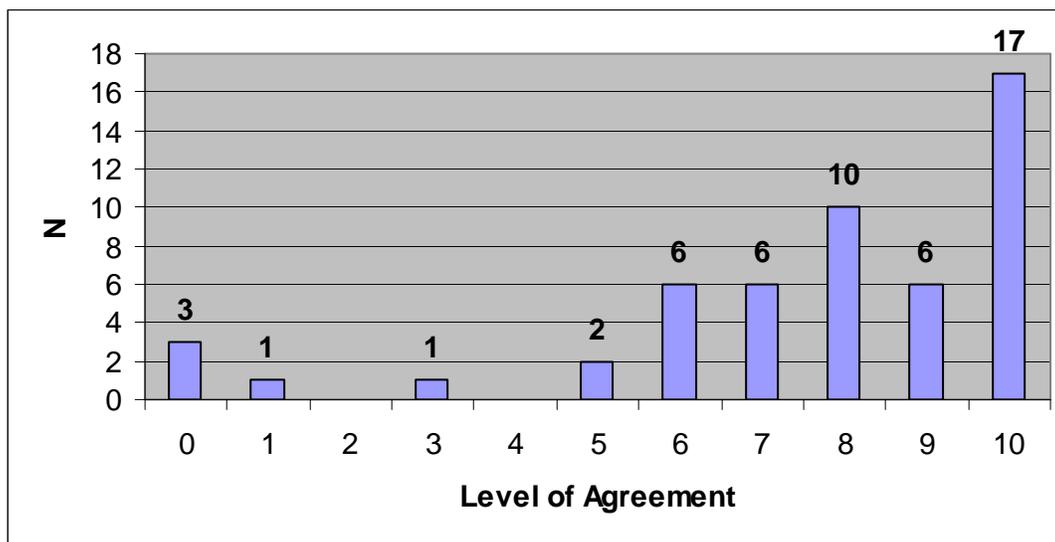


Figure 5: User responses to focus group questionnaire item, “I have applied at least one of the culturally competent communication techniques that I saw in the vignettes in my daily practice” (N=52)

Emerging Theme: The impact of the curriculum on self-awareness related to cultural competency.

Analyses of focus group results rendered a common emergent theme that was not explicitly identified as a research objective. This theme was the impact of the modules on enhancing physicians' self-awareness of concepts related to cultural competency. Most focus group participants included terms related to self-awareness in how they defined cultural competency and provided examples of situations in which the course enhanced their self-awareness.

These results are consistent with the published literature which cites awareness as a critical component of cultural competency development (Campinha-Bacote, 2003; Cross, Bazron, Dennis, and Issacs, 1989). Curriculum module 1.2 focuses on the cultural competency development process and highlights the importance of self-awareness. The finding that participants consistently cited self-awareness during focus groups suggests that curriculum content was retained. Physicians' report of the curriculum's impact on self-awareness may indicate that the course results in advancement of participant cultural competency development.

In particular, physicians stated that the course helped them recognize their own biases and encouraged self-reflection related to their use of interpreters in medical encounters. Several providers also remarked that although they considered themselves culturally competent prior to taking the course, they learned things from the curriculum that they didn't know.

Examples of remarks pertaining to self-awareness include:

The LAS module was a real eye-opener. I don't have a medical Spanish interpreter. I'm lucky and one of the front staff speaks Spanish and does a good job. When that person was off though there was only one other person who could speak Spanish and did a bad job of interpreting. That patient did not get the best medicine [they] could have. A lot of times a family member will get stuck interpreting. If the person spoke English they would've gotten better care- that hit home for me with disparities.

We don't have a very diverse population. But this is an excellent module. It made me think about how I can do things differently. I realized some of my biases.

For me, the language portion was the biggest asset. Being Spanish, I've never worked with interpreters because I always spoke with my patients. Here we have the Sudanese population though, and I've had no training with interpreters because I had never been in that situation. I always thought I was a culturally competent person, but in that situation, I am culturally incompetent.

Results from the focus group questionnaire support these findings. On a scale of 0-10, the mean level of agreement to the statement "Since completing the cultural competency curriculum

modules, I believe I am more aware of my own beliefs and biases and their influence on my interactions with patients” was 8.00 (Figure 6).

The true impact of enhanced self-awareness on daily physician practice will depend on the degree to which specific behavior modifications are made as a result of this self-reflection and awareness. Objective 4 lends support to the notion that some physicians made behavior changes as a direct result of their participation in the cultural competency education program.

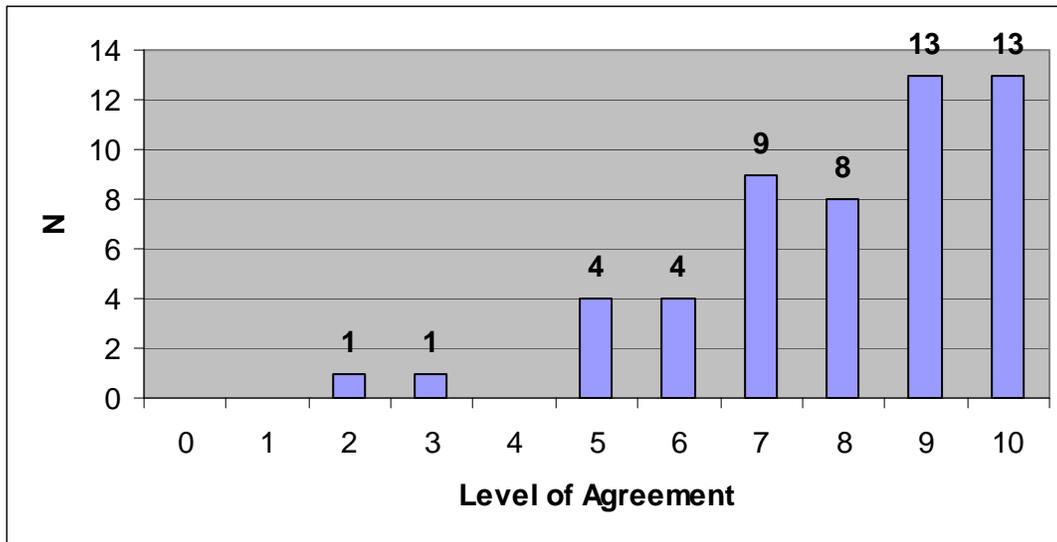


Figure 6: User responses to focus group questionnaire item, “Since completing the cultural competency curriculum modules, I believe I am more aware of my own beliefs and biases and their influence on my interactions with patients” (N=53)

Discussion

The present evaluation reflects an initial attempt to assess the impact of the CCCMs on physicians' knowledge, skills, and attitudes related to culturally competent clinical practice. As this section will discuss; much of this work is exploratory, however, our results do yield suggestive findings about the impact of the program. In short, we find that the CCCMs have reached their objectives and are a promising curriculum; both quantitative and qualitative evidence support this conclusion. Throughout the evaluation process, we were mindful of seeking out negative case examples to provide the most complete picture possible. As with any evaluation, there are limitations and constraints to our data and approach and these are discussed later in this section.

Quantitative Results

Quantitative data find that although physicians appear to enter the CCCMs with a reasonable understanding of cultural competency, curriculum participation is consistent with meaningful score increases on cultural competency knowledge tests. Overall, we find effect sizes to be large.

We do not find any significant differences between the performance of minority and white physicians on cultural competency knowledge tests, and did not find a treatment effect associated with QIO affiliation. Effect sizes are large for all groups.

Qualitative Results

Results offer evidence that curriculum participation renders a positive impact on practice behavior. Examples focused exclusively on changes related to physician-patient interaction. Physicians mentioned that as a result of taking the course, they attempted to be more cognizant and sensitive to cultural differences, took more time with patients, and asked more patient-centered questions. Although few specific examples were provided, there is some evidence to support that physicians used or intended to use the communication techniques presented in the curriculum.

Data also suggest that while physicians did not decide to use an interpreter as a direct result of curriculum participation, the course did result in improved perceptions of medical interpreters and heightened consideration of their qualifications. There was also heightened awareness of the potentially negative implications of using family members as interpreters.

Our analyses further reveal that after curriculum participation, physicians express sympathy for diverse patients whose clinical encounters have been negatively impacted by cultural or language barriers. Physicians felt that culturally and linguistically inappropriate practices by clinicians and front office staff have the potential to influence access to and quality of care provided.

These results suggest that exposure to curriculum content and case studies may stimulate sympathy for diverse patient types who are experiencing barriers to care. The extent to which these feelings and attitudes may translate into behavior change could have the potential to enable more effective care for diverse patient populations.

There is strong evidence that curriculum participation results in enhanced self-awareness of cultural competency concepts. While this is an important result, its ultimate impact on patient care and the potential to reduce health disparities hinges on the degree to which it translates into behavior change in the clinical environment.

Results from physician focus group feedback and questionnaire outcomes generally converge and reinforce our results.

Evaluation Limitations and Constraints

One limitation in the evaluation of this program is its reliance on physician self-report data. While participants indicate that they have changed their behavior to some degree because of course completion, it is possible that they are overstating these changes. It is possible that physicians participating in focus groups may be inclined to overemphasize program impact in the group dynamic because of the presence of the moderator or their colleagues. Research generally supports that physician self-assessment is often incongruent with external assessment (Claridge, Calland, and Chandrasekhara, Young, and Sanfey, 2003; Davis, Mazmanian, Fordis, Van Harrison, Thorpe, and Perrier, 2006). While self-assessment and self-report are not identical activities, these findings support the use of caution for physician self-report data.

We also have concern as to whether knowledge tests accurately capture the extent to which a physician will incorporate cultural competency concepts in the clinical environment. While knowledge tests can assess whether participants have learned discrete pieces of information as a result of completing the course, this measure likely does not capture the degree to which cultural competency knowledge and skills have been integrated into practice behavior. To obtain a further understanding of behavior change, more direct data collection methods such as observation or patient surveys would likely be helpful.

One limitation of the method used for assessing physician attitudes toward diverse patient types is that a baseline measure could not be established because physicians are not exposed to case scenarios prior to viewing curriculum content. Thus, we cannot be sure about the degree of change in attitudes toward diverse patient that was a direct impact of curriculum participation. One strategy to mitigate this limitation would be to have a sample of physicians view case studies and complete self-reflection exercises prior to entering the curriculum and use this as a baseline for comparison.

An alternative method would be to establish a treatment group (physicians who have completed the curriculum) and a control group (physicians who have not taken the curriculum), have the two groups view cultural competency-related case studies, and have them respond to items that assess how the clinician would approach the clinical encounter, what resources they would use, and their reactions from the physician and patient perspective. Ideally, physicians would be randomly assigned to conditions, although there are quasi-experimental methodologies that could be used to establish group equivalency. In any case, comparisons could then be made between the two groups to assess potential attitudinal and behavior differences.

Another method would use patient-level data, such as surveys about patient perceptions of their physician's cultural competency. Physicians could be randomly assigned to a treatment group and a control group, as above, and then patient data could be elicited and analyzed to detect differential patient perspectives. Of course, if the evaluation included patient surveys this would yield multi-level data structures and related analyses would need to employ hierarchical linear models.

The alternative methods specified above pose constraints such as cost and logistical barriers including patient privacy. The more conservative approach used in the present evaluation – which is based on physician self-report – was selected as a cost-effective first step in the evaluation of this program. Our results lay an initial foundation of evidence that the CCCMs are a promising curriculum. Thus, there is now support from which more involved analyses such as a randomized trial can be more rigorously justified.

Recommendations for Further Research

Health outcomes data are required to measure curriculum impact on health disparities. While this evaluation provides evidence that there may be intermediate influences on culturally competent practice (i.e., self-awareness, enhanced patient communication, and changes in the perceptions and use of medical interpreters), at this time, we cannot link curriculum participation to a reduction in health disparities. Initial evidence supports some degree of behavior change and thus the potential to impact health disparities. Further research is recommended to measure this possible impact.

This evaluation provides a small amount of evidence that medical residents may be more likely to incorporate curriculum concepts into their practice. This may be the case because behaviors are less ingrained early on in practice. If this is the case, it would lend support for exposing medical students to cultural competency education early in their career.

We informally explored whether differences in the time elapsed since completing the curriculum may have influenced physician report of the impact of course participation. We did not find a differential persistence of effect. However, this finding is not unexpected because of a small sample size from focus groups. To further ascertain the influence of time on intervention impact, a follow-up questionnaire could be sent to curriculum participants to elicit additional information.

Finally, this evaluation focused solely on physicians who completed the curriculum. A wide variety of other practitioner types also participated in this education intervention. It may be of interest to widen the study population in the future to determine if the impact of the curriculum is sensitive to provider type. However, a number of participants self-report that they are not in a practice setting. As such, research questions pertaining to the curriculum's impact on clinical behavior change would not be applicable to these participant types.

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Appendix A: Coding Protocol

Other Perspectives: Module 1.2, Question 2

Case Study: Geraldine Williams - Managed Diabetes versus Peace of Mind?

How do you feel about the situation? Do you feel sympathy for either Mrs. Williams or Dr. Brown?

Purpose: The purpose of coding this qualitative item is to capture the extent to which curriculum participation may alter physician attitudes toward diverse patient types. Reactions to self-exploration questions about the Mrs. Williams case study serve as the basis for this analysis.

Instructions: Open the Excel file “1.2Q2”
Review the participant response provided in Column C
Enter the numeric code corresponding to each response in Column D
If the response is non-substantive enter a 0
If the response is substantive enter 1, 2, or 3 as described in the following table
Highlight extreme examples of positive responses in **blue**
Highlight extreme examples of negative responses in **yellow**
{ These examples will be used in the results section to demonstrate range }
Save the updated file with the date after the file name, ex. “1.2Q2dec18”

Numeric Code	Description
0	User did not provide a substantive response
1	User expresses sympathy/support for the patient (Mrs. Williams)
2	User does not express sympathy/support for the patient (Mrs. Williams)
3	User provides substantive response but it is neutral toward the patient

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Other Perspectives: Module 2.2, Question 3
Case Study: Maria Gonzalez - "Going Crazy?"

What troubles you the most? Do you have a greater concern with the office and its staff, or with the patient?

Purpose: The purpose of coding this qualitative item is to capture the extent to which curriculum participation may alter physician attitudes toward diverse patient types. Reactions to self-exploration questions about the Ms. Gonzalez case study serve as the basis for this analysis.

Instructions: Open the Excel file "2.2Q3"
Review the participant response provided in Column C
Enter the numeric code corresponding to each response in Column D
If the response is non-substantive enter a 0
If the response is substantive enter 1, 2, or 3 as described in the following table
Highlight extreme examples of positive responses in **blue**
Highlight extreme examples of negative responses in **yellow**
{These examples will be used in the results section to demonstrate range}
Save the updated file with the date after the file name, ex. "2.2Q3dec18"

Numeric Code	Description
0	User did not provide a substantive response
1	User expresses concern/support for the patient (Maria Gonzalez)
2	User does not express concern/support for the patient (Maria Gonzalez)
3	User provides substantive response but it is neutral toward the patient

Appendix B: Intercoder Training

Two individuals coded the self-reflection responses used in evaluation objective 2. To measure intercoder reliability, a random set of 50 responses was double blind coded for each of the self-exploration questions. The agreement rate was .54 and .50 respectively. These rates were considered too low to proceed in coding the entire set of responses to the self-exploration questions. An intercoder training session was held and coding discrepancies were assessed and decision rules established. These decisions are provided below. A second set of random responses was then generated and double blind-coded. Agreement rates were .94 and .90.

Other Perspectives: Module 1.2, Question 2

Case Study: Geraldine Williams - Managed Diabetes versus Peace of Mind?

How do you feel about the situation? Do you feel sympathy for either Mrs. Williams or Dr. Brown?

- The response was coded “1” if the physician expressed sympathy for both the patient and the doctor and provided details to support their reaction.
- If the response was “both,” it was coded as “3.” This response was considered substantive because it makes sense in the context of the case study and question, but was considered neutral because additional detail or explanation was not provided.

Other Perspectives: Module 2.2, Question 3

Case Study: Maria Gonzalez - "Going Crazy?"

What troubles you the most? Do you have a greater concern with the office and its staff, or with the patient?

- If the response was one word consisting of “staff,” “office,” or “patient,” it was coded a “3.” This response was considered substantive because it makes sense in the context of the question, and considered neutral because explanatory details were not provided.

Appendix C: Pre- and Posttest Questions

Theme 1: Culturally Competent Care Pretest

Questions and Answers (in bold)

1. The burden of health disparities continues to disproportionately affect which population(s)?
 - A. The elderly
 - B. Women
 - C. Racial and ethnic minorities [Correct answer]**
 - D. All of the above
2. The CLAS standards were developed to improve access to health care for minorities, reduce disparities, and improve quality of care.
 - A. True [Correct answer]**
 - B. False
3. Which of the following is **not** one of the four factors that recipients of federal funds must balance to determine their obligation to provide LEP services?
 - A. The number or proportion of LEP persons eligible to be served or likely to be encountered
 - B. The nature and importance of the recipient's program, activity, or service to people's lives
 - C. The number or proportion of bilingual staff members in the program [Correct answer]**
 - D. The resources available to the recipient and costs
4. Every clinical encounter is cross-cultural.
 - A. True [Correct answer]**
 - B. False
5. According to the CLAS standards, health care providers should ensure that patients receive which of the following types of care?
 - A. Effective, understandable, and respectful care [Correct answer]**
 - B. Low-cost primary care
 - C. Wellness interventions for children
 - D. Care from physicians who share the patient's language and culture

6. Which of the following statements best describes the appropriate relationship of fact-centered and attitude/skill-centered approaches to cultural competency?
- A. The fact-centered approach should be given preference because facts about specific races or ethnic groups help physicians to define their patients who come from those groups.
 - B. The attitude/skill-centered approach should be given preference because no physician can remember all of the facts relating to multiple cultures.
 - C. **Fact-centered and attitude/skill-centered approaches should be balanced. [Correct answer]**
 - D. The fact-centered approach presents patients as racial stereotypes and should not be used.
7. Research shows that it takes physicians approximately 5 years of practice in diverse clinical populations to achieve cultural competency, although some physicians may reach the goal earlier with special training.
- A. True
 - B. **False [Correct answer]**
8. Which of the following encompasses the definition of patient-centered care?
- A. The physician provides as many services as possible directly to the patient, without relying on office staff or on other health care providers.
 - B. The health care team meets with the patient and his or her family to develop a treatment plan for the patient.
 - C. **The physician is aware of the role of cultural health beliefs and practices in a person's health-seeking behavior and is able to negotiate treatment options appropriately and in a culturally sensitive way. [Correct answer]**
 - D. None of the above.
9. A culturally competent physician should address disease first, then illness.
- A. True
 - B. **False [Correct answer]**
10. Which of the following is the appropriate relationship between traditional health beliefs and evidence-based medicine?
- A. Evidence-based medicine, because of its grounding in science and research, should take precedence over traditional health beliefs.
 - B. Traditional health beliefs should take precedence over evidence-based medicine because patients will comply only with what they believe in.
 - C. **Traditional health beliefs should be integrated or coordinated with evidence-based medicine when possible. [Correct answer]**
 - D. None of the above.

Theme 1.1: Overview of Culturally Competent Care Posttest

Questions and Answers (in bold)

1. Cultural competence has become a national health concern because of political considerations.
 - A. True
 - B. False [Correct answer]**

2. The burden of health disparities continues to affect which population(s) disproportionately?
 - A. The elderly
 - B. Women
 - C. Racial and ethnic minorities [Correct answer]**
 - D. All of the above

3. Providing CLAS to culturally and linguistically diverse patients has the potential to improve which of the following aspects of health care?
 - A. Access to care
 - B. Quality of care
 - C. Reduction of health disparities
 - D. All of the above [Correct answer]**

4. Racial and ethnic minorities tend to receive the same quality of health care as non-minorities when access-related factors, such as patients' insurance status and income are controlled.
 - A. True
 - B. False [Correct answer]**

5. Barriers in access to health care are largely geographic.
 - A. True
 - B. False [Correct answer]**

6. Benefits of cultural competency for physicians and health care organizations include which of the following?
 - A. Reduced malpractice costs
 - B. More positive image in the community
 - C. Administrative and operational efficiencies
 - D. All of the above [Correct answer]**

7. The CLAS standards were developed to improve access to health care for minorities, reduce disparities, and improve quality of care.
 - A. True [Correct answer]**
 - B. False

8. Which of the following, if any, is the correct definition of CLAS standards guidelines?
- A. Current Federal requirements for all practicing health care providers
 - B. Activities recommended by the Office of Minority Health for adoption as mandates by health care organizations [Correct answer]**
 - C. Suggestions by the Office of Minority Health for voluntary adoption by health care organizations
 - D. None of the above
9. Which of the following is **not** one of the four factors that recipients of federal funds must balance to determine their obligation to provide LEP services?
- A. The number or proportion of LEP persons eligible to be served or likely to be encountered
 - B. The nature and importance of the recipient's program, activity, or service to people's lives
 - C. The number or proportion of bilingual staff members in the program [Correct answer]**
 - D. The resources available to the recipient and costs
10. Every clinical encounter is cross-cultural.
- A. True [Correct answer]**
 - B. False

Theme 1.2: Cultural Competency Development Posttest

Questions and Answers (in bold)

1. According to the CLAS standards, health care providers should ensure that patients receive which of the following types of care?
 - A. **Effective, understandable, and respectful care [Correct answer]**
 - B. Low-cost primary care
 - C. Wellness interventions for children
 - D. Care from physicians who share the patient's language and culture

2. Which of the following, if any, encompasses the definition of respectful care?
 - A. Restores the patient to the desired health status and protects future health.
 - B. Focuses on the need for patients to fully comprehend questions, instructions, and explanations.
 - C. **Includes considering the patient's values and preferences. [Correct answer]**
 - D. None of the above.

3. The fact-centered approach to culture teaches cultural information about specific ethnic groups.
 - A. **True [Correct answer]**
 - B. False

4. The fact-centered approach to culture enhances communication skills and emphasizes the sociocultural context of individuals.
 - A. True
 - B. **False [Correct answer]**

5. Which of the following statements best describes the appropriate relationship of fact-centered and attitude/skillcentered approaches to cultural competency?
 - A. The fact-centered approach should be given preference because facts about specific races or ethnic groups help physicians to define their patients who come from those groups.
 - B. The attitude/skill-centered approach should be given preference because no physician could remember all of the facts relating to multiple cultures.
 - C. **Fact-centered and attitude/skill-centered approaches should be balanced. [Correct answer]**
 - D. The fact-centered approach presents patients as racial stereotypes and should not be used.

6. Health care providers should seek each patient's understanding of illness and treatment.
 - A. **True [Correct answer]**
 - B. False

7. Self-reflection about one's cultural identity and beliefs is the most important path to cultural competency.
- A. True
 - B. False [Correct answer]**
8. The road to cultural competency does **not** include which of the following principles?
- A. Developing cultural humility
 - B. Examining family beliefs, roles, and constructs in the community
 - C. Bilingualism [Correct answer]**
 - D. Understanding how race, ethnicity, gender, spirituality, and other issues play a role in both delivery and perceptions of health care
9. Which of the following models, if any, is recognized as the most effective means to achieving cultural competency?
- A. The learning objectives model including intercultural concepts, knowledge, skills, and attitudes
 - B. The 7-stage ethnosensitivity model ranging from fear to integration
 - C. The 6-point continuum ranging from cultural destructiveness to cultural proficiency
 - D. None of the above [Correct answer]**
10. Research shows that it takes physicians approximately 5 years of practice in diverse clinical populations to achieve cultural competency, although some physicians may reach the goal earlier with special training.
- A. True
 - B. False [Correct answer]**

Theme 1.3: Patient-Centered Care and Effective Communication Posttest

Questions and Answers (in bold)

1. Which of the following, if any, encompasses the definition of patient-centered care?
 - A. The physician provides as many services as possible directly to the patient, without relying on office staff or on other health care providers.
 - B. The health care team meets with the patient and his or her family to develop a treatment plan for the patient.
 - C. **The physician is aware of the role of cultural health beliefs and practices in a person's health-seeking behavior and is able to negotiate treatment options appropriately and in a culturally sensitive way. [Correct answer]**
 - D. None of the above.
2. Patient-centered care should be provided to which patient populations?
 - A. **All patients [Correct answer]**
 - B. Minority patients
 - C. Children
 - D. Patients in populations with health disparities for the disease or condition being treated
3. The word "illness" refers to physiological and psychological processes.
 - A. True
 - B. **False [Correct answer]**
4. The word "illness" refers to a patient's meaning and experience of a perceived disease.
 - A. **True [Correct answer]**
 - B. False
5. A culturally competent physician should address disease first, then illness.
 - A. True
 - B. **False [Correct answer]**
6. Which of the following holds the power differential in health care encounters?
 - A. Insurance companies
 - B. Patients
 - C. **Physicians [Correct answer]**
 - D. None of the above

7. Which of the following is **not** appropriately included in the definition of traditional health beliefs?
- A. Traditional health beliefs explain illness.
 - B. Traditional health beliefs are based on cultural beliefs.
 - C. Traditional health beliefs are based on cultural practices.
 - D. Traditional health beliefs are the same as alternative medicine. [Correct answer]**
8. Which of the following is the appropriate relationship between traditional health beliefs and evidence-based medicine?
- A. Evidence-based medicine, because of its grounding in science and research, should take precedence over traditional health beliefs.
 - B. Traditional health beliefs should take precedence over evidence-based medicine because a patient will comply only with what he or she believes in.
 - C. Traditional health beliefs should be integrated or coordinated with evidence-based medicine. [Correct answer]**
 - D. None of the above.
9. Effective medical interviewing includes eliciting the patient's explanatory model for his or her illness.
- A. True [Correct answer]**
 - B. False
10. Which of the following communication models presents nine main domains influencing the care and health status of individuals, families, groups, and sociocultural institutions?
- A. LEARN model
 - B. ESFT model
 - C. ETHNIC model
 - D. None of the above [Correct answer]**

Theme 2: Language Access Services Pretest

Questions and Answers (in bold)

1. Individual physicians, whose **only** federal financial assistance is Medicare Part B are still required by Federal mandates to provide LAS to their patients with limited English proficiency at no cost to the patient.
 - A. True
 - B. False [Correct answer]**

2. Which of the following is **not** a responsibility of health care federal financial assistance recipients under the LAS CLAS standards?
 - A. Provide interpreter services at no cost to limited English proficiency (LEP) patients/consumers.
 - B. Ensure hours of operation that are convenient to LEP patients/consumers. [Correct answer]**
 - C. Inform patients of their rights to receive LAS.
 - D. Ensure competency of interpreters and provide translated materials.

3. Which of the following is the correct order of preference for providing LAS to LEP patients/consumers?
 - A. Family members, bilingual staff, face-to-face interpretation, telephone interpretation
 - B. Bilingual staff, face-to-face interpretation, telephone interpretation [Correct answer]**
 - C. Face-to-face interpretation, telephone interpretation, bilingual staff, family members
 - D. Bilingual staff, telephone interpretation, face-to-face interpretation

4. HIPAA, the Health Insurance Portability and Accountability Act of 1996, prohibits collection of individually identifiable health information.
 - A. True
 - B. False [Correct answer]**

5. Recipients of federal financial assistance should make LEP persons aware that they have the option to receive interpreter services without charge.
 - A. True [Correct answer]**
 - B. False

6. When oral interpretation is not available, translated materials may substitute.
 - A. True
 - B. False [Correct answer]**

7. Notices of patients' rights, including the right to receive language assistive services, should be posted in health care federal financial assistance recipients' offices in languages appropriate to the patient community.

- A. **True [Correct answer]**
 - B. False
8. The word “triadic” refers to which of the following relationships in a medical interview setting?
- A. Provider, patient, family member
 - B. Provider, provider, patient
 - C. **Provider, interpreter, patient [Correct answer]**
 - D. Patient, interpreter, family member
9. Which of the following is the definition of “transparency” in a triadic interview?
- A. All parties agree in advance to be honest in their dealings with one another.
 - B. The patient’s medical history is clearly delineated for all parties.
 - C. **Everything said by any party, including the interpreter, is interpreted in a language that others can understand. [Correct answer]**
 - D. The provider clearly explains all medical terms and ensures that the patient understands them.
10. Which of the following types of interpretation works best?
- A. **Sentence by sentence interpretation [Correct answer]**
 - B. Summarization of each party’s comments by the interpreter
 - C. Any type of interpretation for which the interpreter is trained
 - D. None of the above

Theme 2.1: Importance of Language Access Services Posttest

Questions and Answers (in bold)

- All recipients of federal financial assistance from HHS, except providers who only receive Medicare Part B payments, are required to provide LEP persons meaningful access to their programs and activities.
 - True [Correct answer]**
 - False
- It is important for the provider and patient to be able to communicate in the same language because a common language ensures cultural understanding.
 - True
 - False [Correct answer]**
- Which of the following is **not** a responsibility of health care federal financial assistance recipients under LAS CLAS standards?
 - Provide interpreter services at no cost to LEP patients/consumers
 - Ensure hours of operation that are convenient to LEP patients/consumers [Correct answer]**
 - Inform patients of their rights to receive LAS services
 - Ensure competency of interpreters and provide translated materials
- Which of the following is the correct order of preference for providing LAS to LEP patients/consumers?
 - Family members, bilingual staff, face-to-face interpretation, telephone interpretation
 - Bilingual staff, face-to-face interpretation, telephone interpretation [Correct answer]**
 - Face-to-face interpretation, telephone interpretation, bilingual staff, family members
 - Bilingual staff, telephone interpretation, face-to-face interpretation
- All health care providers who do not provide interpreter services and translated materials to LEP patients/consumers would be considered in violation of Title VI of the Civil Rights Act of 1964.
 - True
 - False [Correct answer]**
- Which of the following would be considered liabilities of inadequate communication with patients according to State laws?
 - Damages resulting from treatment in the absence of informed consent
 - Breaches in professional standards of care
 - Presumption of negligence
 - All of the above [Correct answer]**
- HIPAA prohibits collection of individually identifiable health information.

- A. True
 - B. False [Correct answer]**
8. Benefits that might accrue to health care organizations that provide LAS include good will with immigrant and minority communities and lack of liability.
- A. True
 - B. False [Correct answer]**
9. Which of the following are potential costs to health care providers not offering LAS to patients/consumers?
- A. Taking highly paid professionals away from clinical work to do interpretations
 - B. Canceling surgeries because patient did not understand preoperative instructions
 - C. Caring for sicker individuals in emergency rooms because they could not communicate with primary care providers
 - D. All of the above [Correct answer]**
10. Providing LAS is considered good medical practice.
- A. True [Correct answer]**
 - B. False

Theme 2.2: Models to Provide Language Access Services Posttest

Questions and Answers (in bold)

1. Which of the following would **not** be considered a best practice in interpersonal communication?
 - A. **Calling each patient by his or her first name to create familiarity. [Correct answer]**
 - B. Being conservative in body language.
 - C. Believing a patient's account of the effect of supernatural beliefs on his or her health.
 - D. All of the above.
2. Which of the roles listed below matches this description of an interpreter's role: "Interpreter renders in one language literally what has been said in the other, no additions, no omissions, no editing or polishing."
 - A. Advocate
 - B. Clarifier
 - C. **Conduit [Correct answer]**
 - D. Culture Broker
3. It is important to ensure that an interpreter does not advocate for a patient because advocacy interferes with the objectivity of the interpreter's role.
 - A. True
 - B. **False [Correct answer]**
4. Recipients of federal financial assistance should make LEP persons aware that they have the option to receive interpreter services without charge.
 - A. **True [Correct answer]**
 - B. False
5. Which of the following areas of interpreter practice standards encompasses this definition: "Recognizes and communicates the ways that culturally based beliefs affect the presentation, course, and outcomes of an illness, as well as perceptions of wellness and treatment."
 - A. Interpretation
 - B. **Cultural interface [Correct answer]**
 - C. Ethical behavior
 - D. All of the above
6. Which of the following is a necessary interpreter competency?
 - A. Understanding basic clinical concepts.
 - B. Knowing the workings of the American medical system.
 - C. Applying interpretation skills and techniques.
 - D. **All of the above. [Correct answer]**

7. When oral interpretation is not available, translated materials may substitute.
- A. True
 - B. False [Correct answer]**
8. Notices of patients' rights, including the right to receive language assistive services, should be posted in health care federal financial assistance recipients' offices in languages appropriate for the patient community.
- A. True [Correct answer]**
 - B. False
9. Which of the following is **not** a requirement for a qualified translator?
- A. Previous education, experience, and training in translation
 - B. Membership in the minority group for which the translation is being done [Correct answer]**
 - C. Command of both English and the language into which the material will be translated
 - D. Familiarity with medical terminology
10. Community members should not be involved in reviewing translated materials because they do not have the requisite medical knowledge to appropriately judge the translations.
- A. True
 - B. False [Correct answer]**

Theme 2.3: Working Effectively with an Interpreter Posttest

Questions and Answers (in bold)

1. “Triadic” refers to which of the following relationships in a medical interview setting?
 - A. Provider, patient, family member
 - B. Provider, provider, patient
 - C. Provider, interpreter, patient [Correct answer]**
 - D. Patient, interpreter, family member
2. The provider or patient should speak directly to the interpreter, who will then relay information back to the other party.
 - A. True
 - B. False [Correct answer]**
3. Which of the following would **not** be an appropriate component of a pre-session meeting between provider and interpreter?
 - A. Establishing ground rules
 - B. Clarifying interview purpose
 - C. Providing detailed medical history [Correct answer]**
 - D. Setting goals for the session
4. Because the interpreter speaks both the provider and patient’s languages, the interpreter should maintain control of the interview.
 - A. True
 - B. False [Correct answer]**
5. Which of the following is the definition of transparency in a triadic interview?
 - A. All parties agree in advance to be honest in their dealings with one another.
 - B. The patient’s medical history is clearly delineated for all parties.
 - C. Everything said by any party, including the interpreter, is interpreted in a language that others can understand. [Correct answer]**
 - D. The provider clearly explains all medical terms and ensures that the patient understands them.
6. Which of the following are reasons that triadic interviews require extra time?
 - A. Everything has to be said twice.
 - B. The physician must check to ensure that the patient understands everything and ask that instructions be repeated.
 - C. The interpreter needs time for introductions, to explain the interpreter’s role, and to ensure confidentiality.
 - D. All of the above. [Correct answer]**

7. Which of the following types of interpretation work best?
- A. **Sentence by sentence interpretation [Correct answer]**
 - B. Summarization of each party's comments by the interpreter
 - C. Any type of interpretation for which the interpreter is trained
 - D. None of the above
8. The physician and the interpreter may have sidebar comments because patients who require interpreter services do not usually understand English.
- A. True
 - B. **False [Correct answer]**
9. It is acceptable to use medical jargon during a triadic interview because the interpreter will simplify and explain the concepts to the patient.
- A. True
 - B. **False [Correct answer]**
10. Which of the following would **not** be an appropriate role for an interpreter during a triadic interview?
- A. Interrupting and intervening as necessary to ensure understanding.
 - B. **Answering for the patient. [Correct answer]**
 - C. Asking open-ended questions.
 - D. Interpreting cultural issues as well as language.

Theme 3: Organizational Supports Pretest

Questions and Answers (in bold)

1. The critical element of providing culturally competent medical service is the encounter between patient and doctor; the office environment is **not** significantly important.
 - A. True
 - B. False [Correct answer]**

2. Developing cultural competency and providing CLAS should be included as an integral objective in all the strategic plans of health care organizations.
 - A. True [Correct answer]**
 - B. False

3. With a good strategic plan, the CLAS standards can be fully adopted in most organizations within 6 months.
 - A. True
 - B. False [Correct answer]**

4. Collecting data helps a health care provider or organization do which of the following?
 - A. Increase understanding of health disparities.
 - B. Plan for and implement appropriate cultural and linguistic services.
 - C. Build an epidemiological profile of the community.
 - D. All of the above. [Correct answer]**

5. According to the CLAS standards, health care organizations should ensure that data on a patient's race, ethnicity, and spoken and written language are handled in which of the following ways?
 - A. Collected in health records
 - B. Integrated into the organization's management information systems
 - C. Periodically updated
 - D. All of the above [Correct answer]**

6. Which of the following statements defines a needs assessment?
 - A. Summary profile that includes attitudes, behaviors, needs, and issues or concerns that require resources or attention [Correct answer]**
 - B. Information about practice demographics, along with insurance information
 - C. Demographic information about the patient community, such as population, education, age, and so forth
 - D. None of the above

7. Which of the following are methods by which a provider's offices can cut data collection costs?
- A. Gathering patient demographic data and information about beliefs and attitudes when a patient registers or calls for an appointment
 - B. Adding interview questions to office visits
 - C. Learning if local public health organizations collect data that can be shared
 - D. All of the above [Correct answer]**
8. In improving culturally competent care, it is especially important to ensure that members of minority communities have full access to providing input and participating in community health partnerships.
- A. True [Correct answer]**
 - B. False
9. Which of the following is a benefit of partnerships between health care providers and minority communities?
- A. May help to identify resources and expertise on the community's language, cultural beliefs, or demographic information that can assist providers in offering culturally competent care.
 - B. Can help health care providers to educate community members about specific diseases, risk factors, and health behaviors.
 - C. Can help health care providers to educate community members about prevention.
 - D. All of the above. [Correct answer]**
10. Building partnerships with minority communities assists providers in delivering appropriate services that may be more costly or time-consuming to provide without assistance from community members.
- A. True [Correct answer]**
 - B. False

Theme 3.1: The Importance of Environment/Climate Posttest

Questions and Answers (in bold)

1. The critical element of providing culturally competent medical service is the encounter between patient and doctor; office environment is **not** significantly important.
 - A. True
 - B. False [Correct answer]**

2. Which of the following statements is **not** based on CLAS standards related to environment/climate?
 - A. Implement strategies to recruit, retain, and promote a diverse staff and leadership.
 - B. Ensure that staff receive ongoing education and training in culturally and linguistically appropriate service delivery.
 - C. Conduct organizational self-assessments.
 - D. Conduct a strategic planning process that will help tie compensation to culturally competent care. [Correct answer]**

3. Which of the following is an example of an initiative that health care providers have undertaken in recognition of the importance of office environment in providing culturally competent care?
 - A. Developing training to assist the organization's staff to be more culturally sensitive and to raise awareness
 - B. Doing self-audits to assess how staff members handle the importance of cultural and individual differences, and incorporating their findings into future trainings
 - C. Developing systematic ways to improve practice as a more supportive and encouraging environment
 - D. All of the above [Correct answer]**

4. An organizational self-assessment helps health care providers to examine factors, strategies, and commitment related to offering culturally competent care and to identify those areas that help or hinder effective service delivery.
 - A. True [Correct answer]**
 - B. False

5. Which of the following is **not** a purpose of strategic planning?
 - A. Define and structure goals and activities.
 - B. Structure resources to achieve stated objectives.
 - C. Train staff in cultural competency. [Correct answer]**
 - D. Ensure continual improvement.

6. Developing cultural competency and providing culturally and linguistically appropriate services should be included as an integral objective in all health care organizations' strategic plans.
 - A. True [Correct answer]**
 - B. False

7. Planning should be coupled with evaluation in a continual process to ensure strategic success and continual improvement.
- A. **True [Correct answer]**
 - B. False
8. Which of the following is a principle of successful planning?
- A. Customer (community) input and involvement in the planning and evaluation process
 - B. Decisions based on data, not on assumptions or anecdotes
 - C. An iterative cycle that ensures continual reevaluation of results directed toward further improvements
 - D. **All of the above [Correct answer]**
9. With a good strategic plan, the CLAS standards can be fully adopted in most organizations within 6 months.
- A. True
 - B. **False [Correct answer]**
10. Which of the following statements is an example of how strategic planning can incorporate cultural competency development?
- A. Practice philosophy and mission statement can include cultural competency as an organizational goal or principle.
 - B. Physical plant improvement can include appropriate signage for minority populations.
 - C. Community activities can be planned to develop partnerships with, or learn about culture from, minority groups.
 - D. **All of the above [Correct answer]**

Theme 3.2: Assessing Your Community Posttest

Questions and Answers (in bold)

1. Collecting data helps a health care provider or organization do which of the following?
 - A. Increase understanding of health disparities
 - B. Plan for and implement appropriate cultural and linguistic services
 - C. Build an epidemiological profile of the community
 - D. **All of the above [Correct answer]**

2. According to the CLAS standards, health care organizations should ensure that data on individual patient's race, ethnicity, and spoken and written language are handled in which of the following ways?
 - A. Collected in health records
 - B. Integrated into the organization's management information systems
 - C. Periodically updated
 - D. **All of the above [Correct answer]**

3. Because it may make patients feel uncomfortable to ask them about their race/ethnicity, language, and so forth, it is more appropriate to observe or visually assess the patient for the information.
 - A. True
 - B. **False [Correct answer]**

4. Which of the following are data **not** normally collected in a community profile?
 - A. Population
 - B. Income
 - C. **Weight [Correct answer]**
 - D. Employment

5. Which of the following statements, if any, defines a needs assessment?
 - A. **Summary profile that includes attitudes, behaviors, needs, and issues or concerns that require resources or attention [Correct answer]**
 - B. Information about practice demographics, along with insurance information
 - C. Demographic information about the patient community, such as population, education, age, and so forth
 - D. None of the above

6. Because data analysis and reporting are so complicated, community members should not be involved in designing and implementing data reports.
 - A. True
 - B. **False [Correct answer]**

7. Which of the following is **not** a source for collecting targeted data from individual patients?
- A. **Centers for Disease Control and Prevention (CDC) Web site [Correct answer]**
 - B. Interviews
 - C. Surveys
 - D. Focus groups
8. Collecting patient data is not possible in individual providers' practices because of patient privacy considerations.
- A. True
 - B. **False [Correct answer]**
9. Which of the following are methods by which individual providers' offices can cut data collection costs?
- A. Gathering patient demographic data and information about beliefs and attitudes when a patient registers or calls for an appointment
 - B. Adding interview questions to office visits
 - C. Learning whether local public health organizations collect data that can be shared
 - D. **All of the above [Correct answer]**
10. Because of patient privacy considerations, data should be gathered only for archival purposes.
- A. True
 - B. **False [Correct answer]**

Theme 3.3: Building Community Partnerships Posttest

Questions and Answers (in bold)

1. Health care providers and organizations working with the community can foster “a mutual exchange of expertise that will help shape the direction and practices of the health care organization.”
 - A. **True [Correct answer]**
 - B. False
2. Methods to gain community input would **not** include which of the following?
 - A. Involving community members in planning and advisory committees
 - B. Co-sponsoring community forums and discussions about health care
 - C. Hiring members of minorities to serve as office staff
 - D. **Reading newspaper and magazine reports of community events [Correct answer]**
3. Which of the following is a way in which partnerships could assist partner organizations?
 - A. Addressing individual interests
 - B. Generating public support and awareness
 - C. Creating a critical mass for action
 - D. **All of the above [Correct answer]**
4. Benefits of partnerships should mainly accrue to the entity that provides the most resources to the partnership.
 - A. True
 - B. **False [Correct answer]**
5. Which of the following is a factor that contributes to successful partnerships?
 - A. Mutual trust, respect, and commitment
 - B. Identified strengths and assets
 - C. Clear and accessible communication
 - D. **All of the above [Correct answer]**
6. Which of the following is **not** a recommended option to mitigate the partnership problem that “those most needed at meetings may not be those who most often attend”?
 - A. Develop a mission so that each partner has a significant commitment.
 - B. Mutually agree in advance about each partner’s roles and responsibilities, including meeting attendance and follow-up requirements.
 - C. Communicate regularly and honestly about how well each partner is working as a team member and contributing to the goals of the partnership.
 - D. **Levy fines for those partners who do not attend as required. [Correct answer]**

7. In improving culturally competent care, it is especially important to ensure that members of minority communities have full access to providing input and participating in community health partnerships.
- A. **True [Correct answer]**
 - B. False
8. Which of the following is a direct benefit of partnerships between health care providers and minority communities?
- A. May help to identify resources and expertise on the community's language, cultural beliefs, or demographic information that can assist providers in offering culturally competent care
 - B. Can help health care providers to educate community members about specific diseases, risk factors, and health behaviors
 - C. Can help health care providers to educate community members about prevention
 - D. **All of the above [Correct answer]**
9. Building partnerships with minority communities aids providers in delivering appropriate services that may be more costly or time-consuming to provide without assistance from community members.
- A. **True [Correct answer]**
 - B. False
10. Partnerships with minority communities should mainly involve soliciting input.
- A. True
 - B. **False [Correct answer]**

***Please note: Web sites referenced in this document may not be currently available.*