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Cultural Competence: Essential Measurements of Quality for Managed Care Organizations

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Abstract
We are currently witnessing a radical change in the health care system in the United States as a result of the managed care juggernaut. Driven by the imperative to stem increasing health care costs, managed care seeks to save money by “managing” health care utilization and narrowing the choices available to health care consumers. Although both cost-saving strategies are effective, they also present a potential threat to quality of care. As HEDIS and other measures of quality are revised, physicians must establish guidelines for quality of care that support the burgeoning managed health care environment. In developing these guidelines and measures, two important trends must be acknowledged and addressed. First, managed care was formerly confined mostly to middle class populations but now envelops many more diverse and vulnerable groups, including Medicaid, Medicare, and minority populations [1]. Second, providing care within a managed care environment requires attention to the population of “covered lives” in addition to individual patients.

Disciplines
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We are currently witnessing a radical change in the health care system in the United States as a result of the managed care juggernaut. Driven by the imperative to stem increasing health care costs, managed care seeks to save money by "managing" health care utilization and narrowing the choices available to health care consumers. Although both cost-saving strategies are effective, they also present a potential threat to quality of care. As HEDIS and other measures of quality are revised, physicians must establish guidelines for quality of care that support the burgeoning managed health care environment. In developing these guidelines and measures, two important trends must be acknowledged and addressed. First, managed care was formerly confined mostly to middle class populations but now envelops many more diverse and vulnerable groups, including Medicaid, Medicare, and minority populations (1). Second, providing care within a managed care environment requires attention to the population of "covered lives" in addition to individual patients.

Simultaneously, the demographic characteristics of the United States are rapidly changing. By the year 2000, roughly 25% of the U.S. population will be members of "minority" groups (2). Projections suggest that by the year 2050, ethnic subpopulations will make up 47.5% of the total U.S. population (2), and that by the year 2056, whites will probably be a minority group (3). Furthermore, minority groups are not monolithic, and we must take into account the considerable diversity that exists within U.S. ethnic subpopulations (4). In addition, many of these subpopulations remain disproportionately represented in low-income categories (5), and this too must be factored into guidelines for quality of care.

Of course, the hardest part of this process is actually formulating a set of viable guidelines that will improve the ability of a managed care organization to meet high quality standards in all populations and that will translate into measures of accountability. Such an endeavor is fraught with pitfalls. But the first steps must be to acknowledge the necessity of creating these guidelines and to conceptualize the components of such guidelines.

On this basis, we conceptualize "cultural competence" as the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. But perhaps the most significant aspect of this concept is the inclusion and integration of three areas that are usually considered separately when they are considered at all.

The value of each component is distinct. First, the importance of "cultural sensitivity" or "cultural appropriateness" in delivering health care to a culturally diverse patient population is undeniable, and it is recognized as one variable in the measurement of physician accountability (6). That belief systems play a critical role in medical care has long been acknowledged (7), but interest in the sociocultural aspects of health care has recently intensified as it becomes increasingly clear that the benefit of an approach to healing is often population specific (8, 9). Failure to address the very real issues of cross-cultural communication and variations in health beliefs in the clinical setting certainly threatens patient satisfaction and potentially threatens clinical outcomes. Furthermore, the socioeconomic divide that may exist between the culture of managed care systems and the cultures of vulnerable populations acts as a formidable nonfinancial barrier to care, and this too must be considered (10). Managed care has distinct values and expectations that emerged from and are reinforced by the dominant youth-oriented culture in the United States. The belief systems and perspectives of cultural subpopulations, which are equally valid, may give rise to health-related behaviors that clash with the expectations of the health plan. As they penetrate into Medicare, Medicaid, and minority populations, successful managed care organizations will attempt to negotiate these differences respectfully and proactively—while constantly measuring their own performance.

Second, we believe that effectively managing health care resources for any population requires an epidemiologic perspective. Because disease incidence varies among racial and ethnic subpopulations, managed care organizations that do not have accurate...
programs will probably not use their limited re-

d suspicions within the United States 
have a greater incidence of non-insulin-dependent 
diabetes mellitus (11). Others are afflicted by and 
die from asthma disproportionately (12). Still oth-
er groups, such as the Hmong Vietnamese, have a much 
greater risk for liver cancer than other cultural 
group. Previous episodes of hepatitis. 

Providers who are not guided by such epidemiologic 
knowledge are much more likely to make errors in 
diagnosis and treatment, wasting resources and 
damaging lives (13). If acceptable standards of quality 
are to be maintained with fewer resources, man-
aged care organizations must routinely incorporate 
epidemiologic information into their programs and 
resource allocation decisions and must hold provid-
ners accountable for implementing practice strategies 
to meet the needs of the "lives covered."

Third, a growing body of evidence indicates that 
the efficacy of treatments can vary among different 
and that it is critical that the expected differences 
be integrated into measurements of quality (14, 15). For example, some data indicate that responses to drugs such as angiotensin-converting enzyme inhibitors, diuretics, and β-blockers differ according to race (16, 17), and other data sug-
gests that responses to β-adrenergic agonists differ in black and white patients with asthma (18). Al-
though the cited studies highlight important differ-
ces in treatment response, they focus on individ-
ual patients, not on outcomes in entire populations. 
Clinical researchers are calling for increased efforts 
in exploring population-specific pharmacologic ef-

tects to help ensure accurate diagnosis of disease 
(15), as well as drug safety and efficacy for all 
populations (19). Effective managed care organiza-
tions that accept responsibility for all the popula-
tions they serve will be guided by an awareness of 
this issue and will maintain flexibility in diagnostic 
and treatment protocols or formularies. In an envi-
ronment in which delivering the most cost-effective— not necessarily the cheapest—treatment for 
the populations served will determine the reputation 
and financial success of a managed care organiza-
tion, more research and guideline development in 
this area are clearly needed.

By way of illustration, some important indicators 
of cultural competence for managed care organiza-
tions whose "covered lives" include many minorities 
might include the effectiveness of an outreach program 
for Puerto Rican adolescents with asthma in con-
junction with population-based measures of re-
stricted activity caused by asthma; the percentage of 
pregnant women of low socioeconomic status who 
attend 90% of their prenatal visits beginning in the 
first trimester; mammography rates among minority 
women; and member satisfaction with language and 
cultural translation (or brokering) services (20).

In conclusion, it is imperative at this juncture for the 
medical community to determine what constitutes 
quality of care—particularly for vulnerable 
populations—and to formulate comprehensive and 
viable guidelines for achieving high-quality care in 
all populations. We believe that the concept of cul-
tural competence, when defined as the integration 
of three familiar concepts, generates new, powerful, 
and essential measures of high-quality care for pop-
ulations. Issues of quality and oversight are espe-
cially salient in a health care environment in which 
increasing numbers of lower-income, culturally di-
verse, possibly vulnerable populations are moving to 
a system of care based on limited choice. By includ-
ing cultural competence in assessments of quality 
and by implementing culturally competent systems of care, managed care organizations can make seri-
ous progress toward successfully meeting the health 
care needs of all U.S. populations.

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