

Finding Answers

Disparities Research for Change

Responding to Culture: Beyond Cultural Competence Training



Robert Wood Johnson Foundation

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Credits, Acknowledgements

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Finding Answers: Disparities Research for Change is a national program of the Robert Wood Johnson Foundation with direction and technical assistance provided by the University of Chicago.

Read more about *Finding Answers'* 33 grantee interventions, 11 systematic reviews, and the Roadmap to Reduce Disparities, online at:
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Responding to Culture: Beyond Cultural Competence Training

Disparities in health and health care delivery are widespread and persistent, some of which could be reduced if health care providers and systems were more aware of their patients' cultural background and responsive to those unique needs. At the same time, cultural competence training, the most common approach for improving these issues, is insufficient by itself to improve patient outcomes. This document describes a systematic approach to making health care organizations more knowledgeable and responsive to cultural issues – beyond cultural competence training.

Introduction

Patients' cultural background influences how they experience illness, interact with the care delivery system, and handle care. Cultural background also affects how patients behave and self-manage outside of the clinic.¹ Thus, healthcare workers and organizations must respond to patients' cultural influences in order to provide effective care.² Unfortunately, clinicians frequently do not discuss patients' cultural background during the course of usual care. Cultural competence training can provide a foundation for responding to patient culture but is not enough, by itself, to improve clinical outcomes. Rather, healthcare organizations should systematically identify and use cultural practices, perspectives, and environments to change the way patients and providers interact. Organizations should also integrate patients' cultural practices and perspectives into clinic operations and quality improvement activities. This comprehensive, ongoing approach to patient interaction and clinic operations can have a measurable and concrete impact on patient outcomes.

Culture and Why It Matters

There are many aspects of culture, but generally it can be defined as a combination of “language, norms, beliefs and expectations, and behavioral customs.”² Cultural practices and perspectives can be influenced by race, language, ethnicity, religion, class, or sexual identity though these are only part of a person's cultural identity. Culture also involves the historical and environmental forces that affect groups of people.³ Finally, culture is both individual and social—the community in which a patient lives can impact patients' ability and motivation to manage their care.

In healthcare, responding to culture can include several aspects. These include: 1) identifying specific groups for intervention, 2) tailoring and adapting care to cultural differences, 3) being culturally competent (aware of cultural differences and able to actively solicit and respond to differences^{4,5}), and 4) leveraging cultural differences, or improving minority health by using their cultural practices, environment, and philosophies to “facilitate behavior change of patients or providers.”² By responding to the many aspects of culture, providers and organizations can work more effectively with patients to improve health behaviors, the quality of interactions with providers and organizations, and ultimately patients' health outcomes.

Health care workers and organizations must respond to patients' cultural influences in order to provide the most effective care, but cultural competency training alone isn't sufficient.

A patient's cultural background impacts successful disease management because it affects decisions and behaviors like medication adherence and lifestyle changes. The idea that culture impacts decisions and behavior is not new; the marketing and advertising industries frequently use cultural cues (values, visual images, language, and others) to influence the consumer behaviors of ethnic sub-groups.⁶ Similarly, providers can also use cultural cues to influence and facilitate patient health behaviors by tailoring care plans and self-management skills to fit with a patient's cultural norms and the context of daily life.⁷

Providing culturally appropriate care is especially important for preference-sensitive decisions and decisions that require sustained patient effort outside of the clinic. For example, food choices are sensitive to cultural preferences and require sustained patient effort. A Hispanic patient with diabetes may need additional guidance in how to adapt or moderate traditional foods high in carbohydrates, as well as guidance in negotiating social situations in which food is involved.

Information on patient culture facilitates clear communication between providers and patients and makes it easier for providers to recommend treatment decisions that will work for patients. Better communication also improves both patient and provider satisfaction,⁸ while failing to do so can lead to sub-optimal care. Providers will often need to take the lead in discussing culture since patients may not necessarily volunteer information about their culture. By eliciting this information from patients, providers are better able to engage them in making decisions about care.⁷ Like a patient's family history, cultural background is one more piece of information that can help providers identify what is happening with the patient and the best course of action.

Finally, organizations that respond to culture are more likely to be seen as "relevant," responsive, and trustworthy to their patients. Building trust with patients of all cultures allows organizations to reach more patients than they would otherwise, improve patient satisfaction, and reduce symptoms of strained relationships, like no-shows. Healthy behaviors are unlikely when patients expect that care will not be effective or accept poor disease control as the status quo.¹ Organizations that respond to culture can work more effectively with patients who may not trust the healthcare system or may carry culture-based negative stereotypes about healthcare that prevent them from seeking or engaging in care.² To increase trust, organizations must consistently demonstrate acceptance and inclusiveness. For example, the University of Pennsylvania Health System created a peer coaching intervention, using peer coaches from the same patient population as intervention participants. Doctors nominated coaches from their current patient panels, indicating confidence in these patients' ability to continue to self-manage and share lessons with other patients. This built trust both with the peer coaches and with the patients receiving coaches, resulting in improved engagement for both throughout the intervention.⁹

The skills that help organizations respond to culture are also necessary to adapt to a changing patient population and remain in tune with patient needs. Additionally, organization-level, systematic efforts complement and support providers' efforts to respond to patient culture in their interactions.

Information about culture facilitates patient-provider communication, which improves satisfaction – for both patient and provider.

How to Address Culture

For both providers and organizations alike, the first step in responding to patient culture is to be aware of cultural differences and the degree to which they impact care for individuals. However, providers must put training into action by changing the way they interact with patients. Organizations can support this by linking training with resources and changes in clinic operations to support more culturally appropriate interactions.

Generally, evidence indicates that cultural competence training successfully increases awareness of cultural differences and improves attitudes among providers and staff.¹⁰ Cultural competence training can also provide a starting point for creating strategies to respond to patient culture. However, cultural competence training itself is not associated with improved patient outcomes or reduced disparities,^{10,11} and providers may identify training as overly simplistic. The following experience of Harvard Vanguard Medical Associates illustrates the foundational but introductory role of cultural competence training in responding to patient culture.

Harvard Vanguard identified disparities in their diabetes outcomes and presented monthly “report cards” to providers with their own provider-level disparities data along with cultural competence training to a random sample of their providers. Other providers received no training or reports. Harvard Vanguard expected that the training and report cards would increase provider awareness and thereby reduce disparities in patient diabetes outcomes. The training and information did increase awareness; after the intervention participating providers were significantly more likely to acknowledge disparities, in the organization and in their own patient panels. Patient outcomes, on the other hand, did not improve; there were no significant changes in control of cholesterol, blood pressure, or blood sugar.

Harvard Vanguard’s cultural competence training also successfully highlighted the need for further action. Providers who received the training reported that the training was not enough to address disparities and expressed concern that some disparities-related issues were outside of their scope or ability to impact without organizational support. Conversely, providers who did not receive training or report cards still felt that cultural competence training was a sufficient approach to reduce disparities. This is further evidence that training is a necessary preparatory step—but not the final step—in responding to patient culture.

Providers who successfully respond to patient culture actively observe cultural factors and ask more questions about them in order to give care that is most applicable to their minority patients. They also seek to understand the degree to which these differences exist in and impact individual patients. For example, a given culture may have specific food practices, but an individual patient may also eat many “non-traditional” foods, especially for a given level of acculturation or because of differences in food access. Providers can ask about traditional foods or other cultural practices but provide recommendations and education based on the behaviors and preferences expressed by individuals, rather than assuming that a cultural preference is true of every member of a culture.

Cultural competence training increases awareness of cultural differences and disparities in care, and increase motivation, but alone, it’s not enough to improve patient outcomes.

Organizations that successfully respond to patient culture focus on changing workflows and clinic operations to support culturally appropriate care. They offer data, intervention resources, and resources for patients (such as social workers, language-specific patient surveys and patient education materials, and transportation assistance or other practical help). Organizations can also prepare to answer providers and patients' concerns about using cultural background and can help translate useful feedback from both groups into organization-wide changes.

The following strategies and recommendations for responding to culture are distilled from the experience of Finding Answers: Disparities Research for Change. Finding Answers is a national program of the Robert Wood Johnson foundation that has funded 33 grantees to examine interventions to reduce disparities, as well as completed 11 systematic reviews and provided technical assistance to regional collaboratives working to reduce disparities. These lessons are the basis of [the Roadmap to Reduce Disparities](#), a framework for translating lessons into action.

The Right Way to Do It: Strategies for Considering Culture

Providers and organizations can use these strategies to become more aware of, and actively respond to, patients' cultural differences.

1. Gather information that helps you learn about patients' culture.

Regularly seek information about patients' culture as you work to reduce disparities through workflow changes or other interventions. Input from patients and the community, as well as understanding local environmental factors, provide important information about culture.

Patient input

Patients have the best insight on how their culture affects their care in the context of their daily lives, so organizations should actively solicit their input. Organizations should seek input from current patients, and not rely solely on the guidance of minority staff or on the organization's past experience in order to avoid strategic errors that would decrease participation or chances of success. Minority staff can offer some insight, but they should not replace patient opinions since staff backgrounds and experiences may differ from those of their patients. Similarly, lessons from previous interventions or patient feedback offer some insight but may not reflect the concerns of current patients. Current patients may be at a different level of acculturation or may be experiencing different social, political or economic environments than previous patients.

The experience of two Finding Answers grantees highlights the importance of seeking patient input. The Neighborhood Health Plan of Rhode Island (NHPRI) designed a telephone intervention to address depression for Hispanic patients via phone. They tailored their intervention extensively based on a well-recognized formal framework as well as input from Hispanic staff and providers. But their failure to seek direct patient input resulted in an intervention that did not address the main barriers that patients faced and their main priorities and desires for treatment. As a result, most patients declined participation and the

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intervention failed to show a positive impact on patients' depression outcomes.¹²

Conversely, Cooper Green Mercy Hospital in Birmingham, Alabama illustrated the strong benefit of including patient input from the beginning.¹³ Cooper Green designed a DVD, storytelling intervention grounded in evidence-based behavior change theories and consulted with patients to do so. They conducted focus groups to find out what was important to the members of the community related to their target condition (hypertension) and used that information to create interview prompts. Through filmed interviews, patients generated and delivered the key stories and messages about controlling high-blood pressure. Cooper Green produced DVDs of the stories and presented near-final versions to other patients to verify that they found the stories meaningful and motivating. Soliciting feedback and making adjustments at this stage invited patients to identify any gaps in content or pieces that might hinder the intervention, resulting in excellent products that were well-received by patients. This intervention successfully reduced systolic blood pressure in their intervention population.

Continuing to solicit patient feedback is important since parts of a patient's cultural identity can change over time. For example, a patient who has become a parent may base health-related decisions more on their new parenthood and less on the culture with which they identify. For example, depression and mental health disorders tend to be stigmatized in Latino populations. However, the Yale University School of Medicine (a Finding Answers grantee) had good success recruiting Latino women for depression care by screening them for depression and linking depressed women to care within the context of their children's pediatric clinic. By working through the pediatric clinic, providers were able to screen for depression and then provide care in a way that focused on families rather than individuals, thereby balancing some of the stigma. Working through the pediatric clinic further mitigated stigma by using providers trusted by the women to discuss depression, rather than providing referrals to unknown providers or behavioral health clinics. Yale showed that it was feasible to screen maternal patients in the pediatric setting, and they implemented the screening program long-term in order to continue reaching out to women dealing with moderate to severe depressive symptoms.

Community input

Community input can also provide information that the healthcare organization may not otherwise see. Specifically, community partners can also help engage patients based on relationships of trust. For example, a community recreation center could offer insight into patterns of physical activity that healthcare organizations might not gain through normal care. A more formal relationship, like a Community Advisory Board, would be another way to seek patients' perspectives.

The University of California-Los Angeles joined with many community-based organizations to form the Community Partners in Care collaborative. They reported that developing a collaborative depression intervention network made their depression intervention more valuable than standard depression interventions that are designed and implemented solely within primary care clinics.¹⁴ Community organizations donated space for the project to hold bi-weekly meetings, and it was through these meetings that community organizations helped address many barriers to identifying and caring for

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depression. At each meeting, attendees filled out reflection sheets to get additional frank feedback that was used to adjust the intervention. For example, community partners and intervention staff used the meetings to modify intervention toolkits to best meet the needs and cultural relevance of the community. In one community, partners and intervention staff modified the medication management aspect of the intervention to include training on alternative therapies such as meditation, yoga and aromatherapy, which were of interest in that community.

⇒ See also [this toolkit of patient engagement tools from Aligning Forces for Quality](#).

Environmental factors

Practices should consider how environmental factors (such as current events and politics) can affect how patients perceive intervention efforts. Where possible, plan reasonable “work-arounds” to mitigate the impact of environmental factors that may affect some cultural groups more than others and thus can impact patients’ willingness to communicate with you. For example, race-related tensions in the community or a high level of social stigma related to the condition can prevent patients from engaging with you, no matter how well your efforts mesh with other cultural values. While it is not likely that an organization will resolve such tensions, it can choose different outreach methods or prospectively incorporate messages that anticipate patient concerns related to these environmental factors.

The same Neighborhood Health Plan of Rhode Island (NHPRI) discussed earlier experienced substantial difficulty in their intervention due to environmental factors that they did not account for. Though they carefully designed and tailored their phone intervention to provide depression counseling to Latino patients, at the time of the program, the Latino community was widely aware that Latinos were being targeted for scams over the telephone. Also shortly after the program began, state officials proposed controversial legislation to curb illegal immigration in the state. This highly-charged atmosphere (including protests) raised feelings of fear in the Latino community. Together, these conditions likely heightened reluctance among the target Latino population to answer phone calls from unknown persons, especially to discuss mental health or other medical matters. Thus, the phone-based intervention became difficult to carry out.

2. Build interventions and workflows on patients’ culturally-based values, preferences, and perceptions.

Culture may have a strong impact on patterns of care and patient involvement.

How patients conceptualize and describe a disease

Patients may assume (correctly or incorrectly) that a given condition rarely affects their race/ethnicity, decreasing their motivation to complete preventive screenings or pursue lifestyle change. Strong, culturally-based social stigma attached to a given condition can further hinder effective care, as patients may fail to report symptoms or evade clinician screening efforts. Different cultures may also have a different presentation of symptoms than clinicians are used to,

potentially decreasing the clinician's ability to detect warning signs. For example, populations vary in how they conceptualize and express the physical and emotional symptoms of depression. Asian and Mexican patients may report more anxiety and somatic symptoms of depression and less depressed feelings or emotions compared to White patients.¹⁵ Thus, clinicians should be familiar with different presentations and tailor their screening and treatment protocols to provide the same quality of screening and care to patients of all cultural backgrounds.

Patient treatment/intervention preferences

In addition to how patients perceive the disease itself, culture often affects how patients perceive specific treatment options or outreach methods; providers should be familiar with patients' preferences for care and offer alternate treatment options when necessary. Patients may strongly resist certain therapies based on religious beliefs,¹⁶ expectations about treatment and disease progression,³ level of acculturation,¹⁷ or culturally-based values. Different cultural groups may even ascribe their disease to different causes, prompting them to seek different treatments to match those causes. For example, some Latino and African American patients with diabetes are less likely to attribute depression to negative thinking or to believe that their depression is a reaction to their diabetes, and may differ in other beliefs about disease causes.¹⁸ Latino and African American patients with these beliefs about depression may be less likely to prefer treatments that focus on combating negative thoughts or normalizing it as part of the diabetes experience. As providers become familiar with these differences, they will be prepared to discuss treatment options in a way that both respects patients' culture and maximizes the chances of optimal treatment decisions and health outcomes.

Patients may also hold culturally-based expectations (positive or negative) of what therapy "means" in relation to disease progression. For example, some Hispanic communities perceive insulin as a "last resort," and may even attribute insulin as the cause for complications of diabetes that they have seen in family members or friends who are taking insulin.¹⁹ Such concerns can lead patients to refuse therapy that might improve their diabetes management and thus potentially exacerbate disparities in diabetes outcomes. Conversely, several African American patients in the Cooper Green Mercy Hospital DVDs (discussed earlier) discussed how their hypertension treatments meant something positive: a chance to see their children and grandchildren grow up. As one patient noted, the value she placed on her family gave her the staying power to take her medications regularly and make lifestyle changes.

Family dynamics

In many cultures, family members are highly involved in managing the health of their loved ones. Patients may base decisions on family preferences or how care would impact the family as a whole. Patients' companions can often provide valuable health details to the provider necessary for decisions, and can also act as part of the care team to help follow through with care at home.²⁰ While understanding family involvement is necessary for general quality of care, the degree or type of family involvement may differ by culture. For instance, some Asian communities place higher priority than other racial/ethnic groups on respecting and taking care of elders.²¹ Providers should specifically ask about how cultural norms shape how the family participates in a patient's care.

Culture can affect how a patient describes and conceptualizes disease symptoms, as well as overall treatment preferences.

Care that actively involves family members has a better chance of helping patients follow through on care recommendations. One example comes from the Improving Diabetes Care and Outcomes on the South Side of Chicago Program, a collaborative effort of patients, providers, and the community to improve diabetes care for predominantly African American and Latino patients in Chicago.^{22,23} Part of the program includes patient diabetes classes, where class coordinators have found that involving family members in education allowed patients to make changes they otherwise struggled with. One patient experienced substantial conflict with her spouse as she dealt with the emotional burden of diabetes. As her husband attended class with her, they understood together the impact and coping strategies, and reported a considerable drop in conflict. Another patient struggled to make dietary changes. Though she prepared food according to her diabetes recommendations, one of her adult children (not living with her) visited often and ate the prepared food, making it difficult for this woman to get through the month with enough food. After attending the class, this patient's family member understood what she was learning about managing diabetes and was able to support her in those endeavors. While these patterns will vary between members of a culture, providers should ask patients about the role of their family in order to give care that is most applicable to their minority patients.

Decision making, especially when patients feel ambivalent or reluctant to contradict “authority” figures

In some cases, patients may consciously make decisions based on strongly-held values that providers view as less effective. For example, patients may refuse to follow a care plan (i.e., are non-adherent) as a way to exert control or influence over their care when they have concerns but do not feel empowered to express them verbally to the doctor.^{24,25}

Providers can address these concerns by making it safe for patients to disagree or express concerns and opinions that differ from the guidance they have received. For example, a provider could say, “You might disagree or have other ideas. Can you tell me about other thoughts you have?” Or, “I’m wondering if you have other concerns that you might be nervous about bringing up. I want to hear all of your concerns, no matter what they are.” As providers actively involve patients in shared decision making and build relationships of trust, they will make it more likely that care will fit the patient’s culture and individual needs. For example, a University of Southern California intervention offered patients who were experiencing mild to moderate depression the choice of brief Problem Solving Therapy (PST), antidepressant medication, or both. They successfully increased patients’ access to necessary care. Making it safe for patients to disagree or to choose their own care can also help build trust in the organization as a whole.

3. In creating patient education materials, choose images and language that resonate with the target population.

It would be oversimplifying to say that one message or image will appeal to everyone in a group, but language and images that resonate with your audience can make patients more receptive to the ideas you are offering. Conversely, exclusionary language or images can make patients less receptive. For example, many interventions get abbreviated to acronyms that may not translate well to other languages. One organization targeting

Family members may be an important part of a patient’s decision-making process, so providers should be aware of – and ask about – their preferences.

Hispanic patients learned that they should have chosen a name and acronym for their study that had meaning in Spanish (such as GANAR [to conquer or win] or SALUD [health]), rather than the original program name, D-HELP (Depression Health Enhancement for Latino Patients). This acronym was reasonable in English but meaningless in Spanish and thus did not make the purpose of the intervention clear. Conversely, Massachusetts General Hospital created a culturally tailored depression toolkit that included self-rated depression questionnaires, psycho-educational booklets, worksheets and community resources. Patients reported high satisfaction with the materials.

4. Sustain your organization's efforts to culturally tailor care.

Considering culture is a process rather than a single event. Therefore, organizations must sustain the process over time, including during staff turnover or changes in the patient population. Organizations should provide resources so that healthcare workers can tailor their care for any patient, and hold healthcare workers and leaders accountable for providing culturally-appropriate care.

Responding to staff turnover and holding staff accountable for equity

Even well-designed processes for considering culture can falter when staff leave the organization or are not held accountable for maintaining efforts to improve disparities. The key tasks for responding to staff turnover are: 1) cross-training staff and documenting processes, 2) filling the informal roles of old staff, and 3) setting expectations for new and old staff.

Practices in the Equity Improvement Initiative (EQUII) illustrate the risks of not preparing for staff turnover. In this initiative, practices participate in regional collaboratives to reduce disparities for a targeted group of patients. Several participating practices have needed to delay their interventions for weeks and even months as they battle with the challenges of staff turnover because they did not cross-train staff, or remaining staff lost momentum when the equity “champion” left the organization. When personnel leave, identify ways that other staff can advocate for your project and provide pragmatic suggestions. Next, organizations should set expectations with both new and old staff that equity is a continuing focus. Job descriptions should include equity responsibilities, and orientation trainings should include cultural competence training. To help new staff move beyond awareness to action, provide direction and accountability around how to actually respond to the disparities and cultural differences that staff observe.

Organizations can help maintain an ongoing focus on disparities by making equity goals a regular part of staff performance reviews and looking for disparities in clinical performance measures. For example, Harvard Vanguard (discussed earlier) presented their provider-level report cards monthly, with opportunities for continuing discussion about progress and strategies to continue improving. Wheaton Franciscan Healthcare in Southeast Wisconsin (one of the EQUII practices) created an equity-based mission statement and five-year strategic plan in order to ensure accountability at every level of the organization.

Responding to changes in the patient population

Even successful programs for considering culture can falter due to staff turnover or competing priorities: a plan for cross-training and succession can help.

Given the importance of responding to patient culture, healthcare workers should be able to respond to culture for any population. Responding to culture for a changing patient population includes periodically re-assessing and responding to patient needs, preferences, and other cultural factors. Again, practices in the Equity Improvement Initiative illustrate this principle. Most of the participating practices work with low-income and transient populations and must frequently assess the issues that face their patients. For example, the Jericho Road Community Health Center, in Buffalo, New York was aware of increasing diversity among their African American patients, including a growing Somali population. They understood that they needed to re-assess the state of their current population and were able to identify where the greatest disparities existed. Understanding the needs of their sub-populations allowed Jericho Road to create a diabetes intervention specifically targeted to the Somali language and culture, rather than relying on broader “African American” groups as they had done previously.

Responding to Culture in Quality Improvement and Incentive Programs

In addition to responding to culture in patient care, organizations should include culture in quality improvement efforts to optimize the care of all patients. Responding to culture applies to incentive programs as well; emerging research indicates that simply meeting the general requirements of an incentive program does not necessarily lead to reduced disparities.²⁶ Thus, all organizations, including those pursuing advanced practice transformation, should pay specific attention to culture in every aspect of care and in their quality improvement and incentive programs.

Conclusion

Cultural tailoring is essential for patients to receive the best care and outcomes from providers and health care organizations. By responding to culture systematically and consistently, organizations are more likely to mitigate barriers to good health and engage patients in their care. Tailored care is a key part of the solution for reducing health disparities.

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