



Cultural Competence as a Quality Issue: Practical Steps to Improvement

Tutorial 21



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Funded by HRSA
HIV/AIDS Bureau

The National Quality Center is pleased to bring you the Quality Academy, an online learning opportunity on key quality management concepts. The NQC provides no-cost, state-of the-art technical assistance for all Ryan White Program grantees to improve the quality of HIV care nationwide. The Center is funded through a cooperative agreement with the HRSA HIV/AIDS Bureau and managed by the New York State Department of Health AIDS Institute.

This Tutorial is titled:

Cultural Competence as a Quality Issue: Practical Steps to Improvement

Learning Objectives: You Will Learn About...

- Basics of cultural competency
- How improving cultural competence impacts HIV care
- How to implement a quality improvement effort in your program to address cultural and health disparities

Hello and welcome to the National Quality Center's Quality Academy.

In this Tutorial we will take up the issues of health disparities and cultural competence. Using the Model for Improvement, we will show how your quality management program can be used to improve your agency's cultural competence and your ability to care for diverse populations. We will follow a health center in their efforts to conduct an improvement project on this important topic.

We thank you for your interest in the National Quality Center and hope that you enjoy this tutorial.

Road Map

- Background on cultural competency and health disparities
- Steps to Improvement:
 - Step One: Baseline Assessment
 - Step Two: Deciding on an Improvement Aim
 - Step Three: Defining a Performance Measure
 - Step Four: Planning and Testing Improvements

This Tutorial will offer some basic information about cultural competence and health disparities and how they impact HIV care. Then, we'll walk through a four-step process for launching a culture and disparities quality improvement effort in your program, starting with Step One: Baseline Assessment, moving to Step Two: Deciding on an Improvement Aim, Step Three: Defining Useful Measures and finally Step Four: Planning and Testing Improvements.

Case Study: Ms. P and the PHC

- *Ms. P, a 40-year-old African - American woman, is newly diagnosed with HIV and receiving care in the Positive Health Center (PHC). On her third visit, her doctor, who is white, prescribes antiretroviral medications. Ms. P has heard that HIV medications might not work as well for African - Americans, but she doesn't want to rock the boat, so she keeps quiet about her doubts and accepts the prescription, but does not fill it.*



Before we start, let's look at an example of one Part C program's approach. We'll follow the Positive Health Center (PHC) throughout this Tutorial. Let's take a moment now to read Ms. P's story and think about how it does or doesn't match the experience of clients in your program.

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Case Study: PHC Quality Committee



Eventually, Ms. P talks about her doubts to a friendly medical assistant at the clinic, who helps her bring it up with her doctor. Clinic staff are concerned by Ms. P's story and worry that it may be part of a bigger pattern. The PHC quality committee decides to conduct an assessment of how well their program is serving the different racial and ethnic communities in their area.

Health Disparities

“Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities.”

- *Institute of Medicine*
2002



The challenges Ms. P is struggling with are not unique to her. When historical or current discrimination, misunderstanding, or poor access to health care interfere with a particular group getting or using needed services, health disparities can be the result.

Disparities based on race and ethnicity are getting long-overdue attention in recent years. In the landmark 2002 publication “Unequal Treatment,” the Institute of Medicine summarized decades of studies, and said, flatly, “racial and ethnic minorities [in the U.S.] tend to receive a lower quality of health care than non-minorities, even when... insurance status and income,” are taken into account. The HRSA HIV/AIDS Bureau has made reduction of disparities in HIV care and improved health outcomes a high priority for the Ryan White Program.

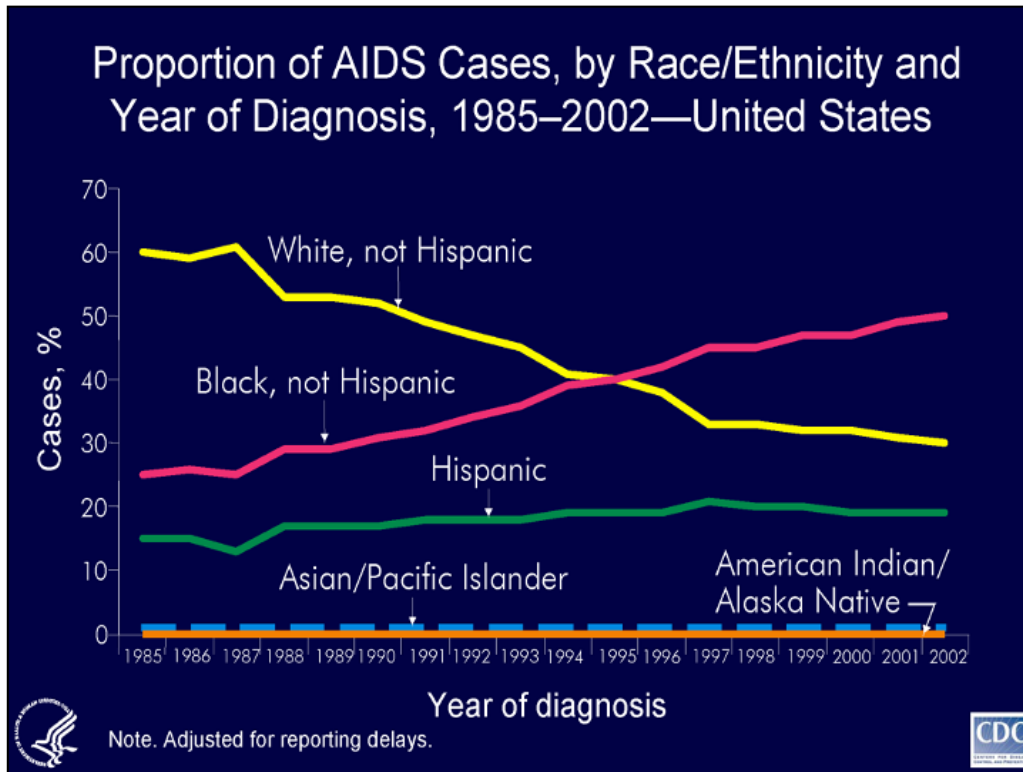
Examples of Disparities

Health disparities can appear as differences in:

- Prevalence rates of illnesses
- How treatment is delivered
- Outcomes of care



Health disparities can appear as differences between groups in the rates of certain illnesses, or in how treatment is delivered, or in outcomes of care. Examples of each of these types of disparities have been well documented and published among people with HIV living in the U.S.



The widening prevalence disparities in HIV are probably familiar to you from these CDC data. HIV disproportionately affected black and Latino populations in the U.S during this time period. AIDS cases among Black Americans almost doubled since the beginning of the epidemic while the proportion of cases among Whites decreased by 50%. Black Americans make up 13% of the population in the U.S., but represent an estimated 49% of people newly diagnosed with HIV or AIDS in 2005, and Latinos with the second highest rate among racial and ethnic groups are also disproportionately affected.

Question

Using the chart on the prior slide as a reference, which statement is true:

- A. AIDS cases among whites have gone down since 1987
- B. AIDS cases among Hispanics and Black, non-Hispanics have stabilized since 1988
- C. AIDS cases among Asian/Pacific Islanders have shown a sharp increase since 1987
- D. AIDS cases among Black, Non-hispanics have almost doubled since 1985
- E. A and D are true**

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- E. A and D are true**

E is the correct answer

Health Disparities in the Delivery of Treatment and Outcomes of Care

- **Entry into care** - African - Americans and Latinos are likely to be diagnosed at a later disease stage than whites¹
- **Starting treatment** - African - Americans in one large national sample study were 59% less likely than whites to be receiving HAART²
- **Success with treatment** - 63% of African - Americans had an undetectable viral load after one year of treatment vs 92% of whites³

1. Losina E, Schackman R, Sadownik S, et al. Disparities in survival attributable to suboptimal HIV care in the US: Influence of gender and race/ethnicity [abstract 142]. Presented at: 14th Conference on Retroviruses and Opportunistic Infections; February 25-28, 2007; Los Angeles, California.
2. Wilson Lucy, Korthuis P, Conviser R, et al. Rural Versus Urban HIV/AIDS Clinical Outcomes: A Multi-state Perspective [abstract 974]. Presented at: 14th Conference on Retroviruses and Opportunistic Infections; February 26, 2007; Los Angeles, California.
3. Hartzell J, Spooner K, Howard R et al. Race and mental health diagnosis are risk factors for Highly Active Antiretroviral Therapy failure in military cohort despite equal access to care. *Journal of Acquired Immune Deficiency Syndrome*. 2007; 44(4): 411-416.

Health disparities also exist in the delivery of treatment and the outcomes of HIV care. Nationwide, people of color are likely to be diagnosed in later stages in HIV illness and, as these example studies illustrate, they may be less likely to be taking antiretroviral (ARV) treatment once in care; African - Americans in one large national sample study were 59% less likely than whites to be receiving highly active antiretroviral therapy (HAART).

Once on ARV treatment, minority patients in many studies are less likely to show virologic success; 63% of African - Americans had an undetectable viral load after one year of treatment vs 92% of whites in this study from the military published in 2007.

Getting Health Care Disparities on the Quality Improvement Agenda

- National data
- Local concerns
- Federal requirements as outlined by the National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards)
 - Maintained by the Office of Minority Health
 - Has 14 standards centered around:
 - culturally competent care
 - language access
 - organizational supports for cultural competence
 - Can be found by following this link:
www.omhrc.gov/assets/pdf/checked/finalreport.pdf

Depending on your program, familiarity with these and other national data about HIV disparities might be enough to put disparities and cultural competence on the quality improvement agenda. In other situations, a personal story like Ms. P's or reports of complaints or concerns about program language capabilities or staff and client mismatches may be a starting point for a disparities assessment.

If your program is part of a larger organization with many competing priorities, you may have trouble getting HIV disparities on the quality agenda. If so, you can refer to the Federal Standards on Culturally and Linguistically Appropriate Services. The CLAS standards address the importance for health organizations of knowing about and collaborating with the ethnic communities they serve. Any organization receiving federal funds (including Ryan White Program grantees) is required to comply with the part of the standards that address language services.

Cultural Competence

“Cultural competence is a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations.”

HRSA Care Action Bulletin 2002

Cross et. al. 1989 and Lavizzo-Mourney and Mackenzie 1996 as cited in Cultural Competence: A Journey, Bureau of Primary Health Care, Health Resources and Services Administration, US Department of Health and Human Services, n.d.)

Many programs are targeting improved cultural competence to tackle the problem of health disparities. An internet search under cultural competence will reveal several definitions and some competing names, including “cultural fluency,” “cultural humility” and “culturally affirmative practice.” HRSA in its documents uses “cultural competence,” and the operational definition of “a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations.”

Question

Examples of disparities in healthcare can include:

- a. Prevalence rates of illnesses
- b. How treatment is delivered
- c. Outcomes of care
- d. All of the above**

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- a. Prevalence rates of illnesses
- b. How treatment is delivered
- c. Outcomes of care
- d. All of the above**

D is the correct answer

Cultural Competence

What do you know about the following health-related patterns of your clients and their families?

- Beliefs
- Attitudes
- Practices
- Communication strategies

There are many elements that make up a program's cultural competence. One important set of questions is whether and how your program finds out about the health-related beliefs, attitudes, practices, and communication strategies of your clients and their families. This understanding is important for improvements in care for individual clients and improved satisfaction with care.

Cultural Competence

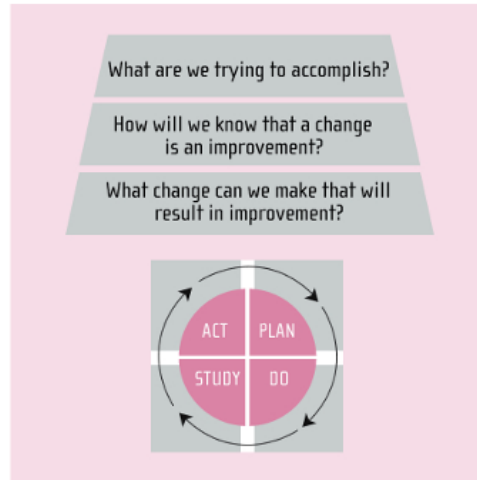
How does your agency understand your clients' unique cultural needs?

- Provide cultural and linguistically competent care
- Strengthen system level
- Increase community participation
- Close gaps in health status

At the program level, your agency's program's cultural competence is demonstrated by how you use your understanding of your clients to address cultural and linguistic competence, improve client services, strengthen your programs, increase community participation and close gaps in health status.

Steps to Improvement: The Model for Improvement - Plus One

Step One: Baseline
Assessment:
How do we know how
well we are doing?



This graphic summarizes the Model for Improvement. You may already be familiar with this Model; if not, you can review it in Tutorial 12 “How to Get Started with Quality Improvement Teams.” The Model uses three useful centering questions:

- What is our *aim*; that is, what are we trying to accomplish?
- What is our success *measure*; how will we know that a change is an improvement?
- And finally, how can we *improve*, what changes can we test that might bring our performance closer to our aim?

These three centering questions are followed by the PDSA, Plan, Do, Study, Act Cycle of testing for each change we try.

For work on cultural competence and disparities, we will add a question to the familiar three: Step One: Baseline Assessment; *How do we know how well we are doing?* Let’s start with that and look at the kind of information about your program that you might gather to start your improvement project.

Question

True or False

Cultural competence can be defined as "a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations"

True or False

Cultural competence can be defined as "a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations"

The correct answer is True

Step One: Baseline Assessment

How do we know how well we are doing?



- Patient Input
- Organizational Self-Assessment
- Performance Data by Race and Ethnicity

As with any quality effort, you will need data to guide the work you do on cultural competence and disparities. Both quantitative and qualitative data can be useful as a starting point. One useful strategy is to start with a three-tier assessment; bringing together patient input on the issue, conducting a qualitative review of your organization's cultural competence infrastructure, and drilling down into your existing performance data to stratify results by group. Let's talk a bit more about these three strategies.

Step One: Baseline Assessment

Patient Input

- Stratify patient satisfaction survey results: Are there differences in satisfaction in different racial or ethnic groups?
- Survey a sample of patients about the cultural competence of your agency
 - “Do you feel welcome in this clinic or do you feel like an outsider? Have you ever felt like you might get better care at your clinic if you were from a different racial or ethnic group?”

A core principle of quality improvement is that improvements are most successful when they address the needs of those we serve, so examining needs and gathering patients' experiences is a critical early step. You can get a first level assessment of a need for improvement by stratifying results from your existing patient satisfaction survey and looking for differences in how clients rate key aspects of care. Or you might consider doing a focused survey of clients asking specific questions about how they experience the cultural competence of your agency, such as “Do you feel welcome in this clinic or do you feel like an outsider? Have you ever felt like you might get better care at your clinic if you were from a different racial or ethnic group?”

Step One: Baseline Assessment Organizational Self-Assessment

- Knowing the community you serve
- Ability to collect data on race, ethnicity and primary language
- Hiring and training policies
- Translation and interpretation services
- Assessing and addressing health beliefs
- The assessment tool can be found by going to:
<http://www.aidsetc.org/doc/workgroups/cc-question-bank.doc>

Another way to approach a baseline agency assessment is to have your quality committee complete and analyze one of the organizational assessments of cultural competence that are available from HRSA and other sources. The link you see will take you to one example of an organizational assessment. The tool takes you through 6 domains including what your organization knows about the ethnic and cultural makeup of your community, how diversity is handled in hiring and training of staff, how you handle translation and interpretation for clients with limited English, and how your intake practices and day-to-day details of care take cultural differences into account. The process of completing the self-assessment can be a great jumping off place for discussion about where your site wants to go, and where you can start to work to improve cultural competence and disparities.

Step One: Baseline Assessment Performance Data by Race and Ethnicity

*Case Study: PHC Data
Collection Challenges*



A third assessment strategy is to drill down into your performance data results to look for differences among your target groups. This may not be as simple as it sounds.

Let's go back again to our case study. The PHC quality committee has asked for baseline data with a breakout by race, ethnicity and primary language spoken of all performance data results and client satisfaction data from the past year. The quality management coordinator comes back the next month with bad news. In 43% of the records in the electronic data system, race and ethnicity are listed as "other/not recorded." Primary language spoken is unrecorded in 32% of the records.

Performance Data by Race and Ethnicity

- How and by whom are race, ethnicity and language data collected?
- Staff may be guessing or avoiding the question
- Asking patients directly gives the most reliable results

Hasnain-Wynia R. and D.W. Baker. "Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions." *Health Services Research*. August 2006; 41(4p1):1501-18



Collecting race and ethnicity data may seem simple, but it's not. Your cultural competence quality effort may need to begin with investigating how race, ethnicity and language data are collected and recorded in your program. People often find it difficult to ask about race, so in many organizations the "eyeball test" – in other words, staff observation—may in practice be how patients' race or ethnicity is determined most often. This is not ideal; research suggests that asking patients to identify their own race or ethnicity yields the most reliable answers.

Performance Data by Race and Ethnicity

- Train staff on why race and ethnicity data are important
- Provide a script:
 - *“We use this information to monitor care to ensure that all patients get the best care possible.”*
 - *“How do you describe your race or ethnicity?”*

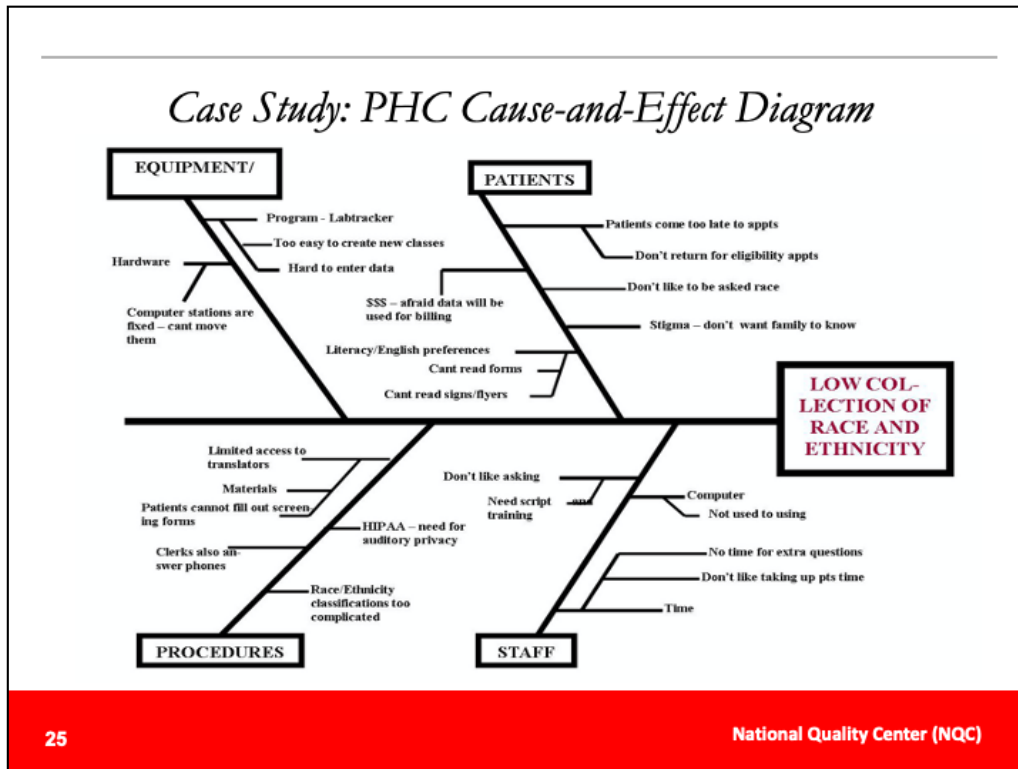


To determine what the Federal category is for a patient's race/ethnicity, go to:
www.whitehouse.gov/omb/inforeg/re_app-a-update.pdf

Seigal B. “Enhancing Public Hospitals’ Reporting of Data on Racial and Ethnic Disparities in Care.” *The Commonwealth Fund*. January 2007

One step in improving your data is to provide training for staff on how to ask for race, ethnicity, and language information; and *how you do it* is important. One large hospital in Chicago tested scripts for staff to use when asking for information on race. Patients were most comfortable when told that the information would be used “to monitor care to ensure that all patients get the best care possible.”

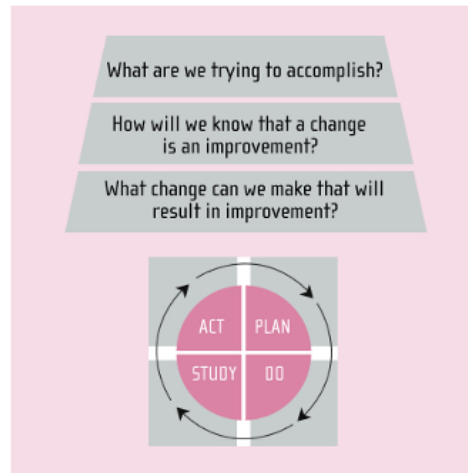
Staff should ask patients to identify their own race or ethnicity, should write down what they say, and then use the federal algorithm to determine what the federal race and ethnicity category is for this patient.



The PHC takes two months to investigate the problems with race and ethnicity data. They start with a special joint meeting of the staff and the Consumer Advisory Board and together create a Cause-and-Effect Diagram describing the process of collecting the information and points where it might go better. They develop and implement a training program for the intake staff, and the next data set shows the race and ethnicity data fields are 85% complete.

Step Two: Deciding on an Aim What Are We Trying to Accomplish?

Step Two: Deciding on an
Improvement Aim



Having completed Step One (baseline assessment) the PHC quality committee is now ready to review and discuss their results and move to Step Two, deciding on an improvement aim. Using the Model for Improvement, in Step Two we ask the question: “What are we trying to accomplish?”

Case Study: Deciding on an Aim

Data Findings:

PHC discovers that only 50% of their African - American patients and 60% of Latino patients have undetectable viral loads while on ARVs, compared to 75% of their white patients

Concrete Aim:

Improve the success rate of African - American and Latino patients on ARVs to 75%

The PHC quality committee discusses their satisfaction and performance data, now broken down by group, and discovers that only half of their African - American patients and 60% of their Latino patients on antiretroviral treatment have undetectable viral loads, compared to 75% of their white patients.

They also review the results of a focus group. Spanish-speaking clients reported they weren't getting enough information about medication and side effects. Review of the cultural competence organizational assessment they did together shows that staff are not being trained on how to work with medical interpreters. The committee decides to tackle these problems together, with the primary aim being to reduce the disparity in ARV success rates.

Based on these findings, the quality committee developed an aim statement.

Step Two: Deciding on an Aim

What Are We Trying to Accomplish?

Disparities manifest in:

- Retention in care
- Viral suppression
- Timing of ARV prescription
- Late presentation for care

Do your data show any problems here?

Turning back to your program, once you know how your clinical quality data are being collected, and have a baseline sense of your program performance, your quality committee will want to look at some reasonable areas to begin focusing on in your improvement work. Across the nation, the most consistent disparities seem to be in retention, rates of viral suppression, timing of ARV prescription, and late presentation for care, usually measured by first recorded CD4 cell count.

Do your data show any problems here?

Your quality committee may also decide to focus on organizational improvements in areas identified on your organizational cultural competence assessment.

Step Two: Deciding on an Aim What Are We Trying to Accomplish?

- Health outcomes
- Retention in care
- Access to care
- Satisfaction with care
- Organizational infrastructure

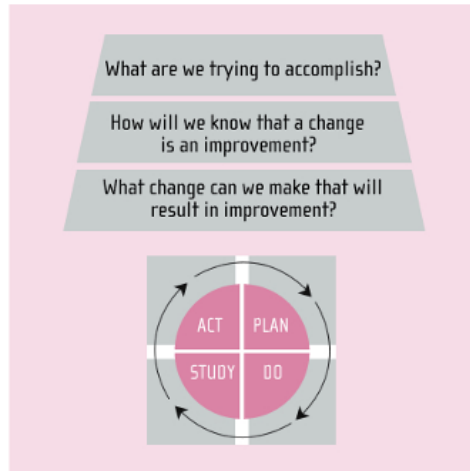
Your data and the nature of the services you provide will determine what kind of aim you might use; here are some likely categories:

- Reduced disparities in health outcomes, for example, a Part C or D program might work to reduce gap between groups in rates of undetectable viral load.
- Retention in care, for example a Part B program might improve a disparity in % of clients from different groups who fail to recertify for ADAP.
- Access to care, an EMA or TGA might focus on a problem of late entry into care or % of patients from different groups who are lost between testing and care sites.
- Satisfaction with care, improving satisfaction with care for particular racial, ethnic or language groups could be an aim for any level program. And
- Strengthening the organizational cultural competence infrastructure based on standardized assessment tools we mentioned before.

Step Three: Defining Measures

How Will We Know a Change Is an Improvement?

Step Three: Defining a Performance Measure



Having chosen an aim, the next step in the Model for Improvement is to define measures, answering the question: How will we know a change is an improvement?

Step Three: Defining Measures

How Will We Know a Change Is an Improvement?

- Compare all groups to the group with the best results
- Measure changes for each individual group
- Changes in the gaps between groups

When the aim is the reduction of health disparities, reporting quantitative data requires some special thought. The standard disparities measurement approach is to display raw results for each group and then a gap. Another approach is the disparities analysis in which the results for all groups are compared with the group that has the best results (usually called “the advantaged group”). Remember to pay attention to issues of statistical significance if some ethnic or racial subgroups are represented by small numbers in your database.

You might be tempted to simplify your data reports, skip the disparities analysis and just follow the raw results for each group. Remember that, as a result of your improvement efforts, rates for all groups might improve but disparities *between* groups can be stalled—or could even be increasing. You may miss that if you aren’t regularly following the disparities gaps in your data.

Step Three: Defining Measures

How Will We Know a Change Is an Improvement?

Look for overall improvement **AND** narrowing of racial and ethnic gaps in:

- % of patients undetectable on ARVs
- % of clients with broken appointments
- % of patients diagnosed with AIDS within one year of HIV diagnosis
- % of patients satisfied with the language services they received

Here are some examples of how you can tell if your changes have made an improvement. The narrowing of racial and ethnic gaps in the percent of patients who are undetectable on ARVs would be a health outcome improvement.

The narrowing of gaps in the percent of clients with broken appointments, and in the % of patients presenting with an AIDS diagnosis within 1 year of first HIV test would be an improvement in retention in care.

Improvement in the percent of patients using interpreter services who are satisfied with the language services they received is an improvement in satisfaction with care.

Case Study: PHC Performance Measure

Data Findings: PHC discovers that only 50% of their African - American patients and 60% of Latino patients are undetectable on ARVs, compared to 75% of their White patients

Concrete Aim: Improve the success rate of African - American and Latino patients on ARVs to 75%

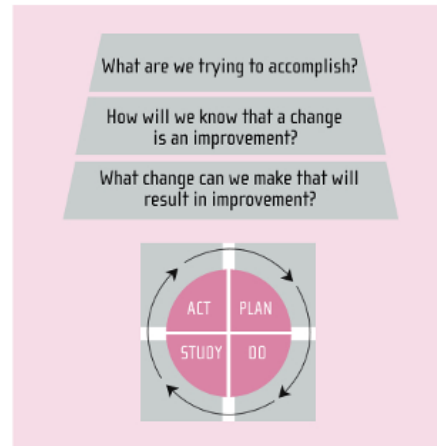
Measure and Goal: The rate of African - American and Latino patients on ARVs at least 6 months who have undetectable viral load increases to at least 75% and the gap with White patients decreases to <5%

You are already familiar with the PHC data finding and aim statement. Here's what the PHC quality committee decided on for their measure. They want to raise the rate for Latino and African - American patients on ARV therapy for 6 months so that there is less than a 5% difference between rate of White patients on ARV therapy to that of African - American and Latino patients.

Step Four: Planning and Testing Changes

What Change Can We Make That Will Result in an Improvement?

Step Four: Planning and Testing Changes



The final step in the Model for Improvement is to plan and test changes; answering the question: What change can we make that will result in improvement?

Changes to Test

Goals	Changes to Test
Care Delivery	
Better communication with clients through improved understanding of their cultural health beliefs.	<ul style="list-style-type: none"> •Add questions about spiritual or religious beliefs to intake and develop a resource list of HIV-friendly local religious groups to give out. Have a staff member ask clients on HAART whether they have concerns about how the medications work for different racial groups. •Add a question about clients' use of alternative health treatments or practitioners.
Improve clients' trust and comfort with the program by reflecting the race/ethnicity of the people served.	<ul style="list-style-type: none"> •Hold a group visit with patients of the same race/ethnicity, to discuss nutritional habits, how these habits could contribute to disease status and offer culturally appropriate alternatives. Offer clients choices of whom to get adherence counseling from; include at least one staff member of the client's race, where possible, and one non-professional/peer staff member.
Improve patients' access to interpreter services and materials in their primary language.	<ul style="list-style-type: none"> •Morning "huddle" of staff to highlight in advance which patients will need interpreters and notify/remind the interpreter services department. •Include an assessment of health literacy as part of intake for all LEP patients.
Consumer Involvement	
Incorporate consumers' ideas and preferences by getting culturally-specific feedback and input from clients.	<ul style="list-style-type: none"> •Focus one CAB meeting on feedback about and improvements in the cultural competence of the organization. Ask clients after visits if cultural issues were discussed and whether they were satisfied with the provider's sensitivity to their culture.
Organization/Infrastructure	
Increase organizational awareness of cultural issues and accountability for addressing organizational weaknesses in this realm.	<ul style="list-style-type: none"> •Collect and report quality data broken down by race and ethnicity. •Begin using an organizational assessment on a regular basis (at least once per year) and use it to decide on improvement priorities. Test different ways of communicating results to staff, leadership, and patients.
Increase alignment of personnel policies and procedures with cultural competence goals.	<ul style="list-style-type: none"> •Add performance on cultural competence-related tasks (like data collection) to all job descriptions and evaluations. Develop and use a list of places to advertise new jobs that are likely to be seen by applicants who reflect the agency's client population.

Your own quality committee, staff and patients will have the best ideas for changes to test. Depending on your aim, you might want to look at details of your care delivery, how consumers and communities give direction and input into your program, or how your organization approaches diversity and culture issues. This table lists several possibilities for you to consider that are especially suited for Ryan White Program grantees. You may wish to pause this training to review all these possibilities.

Case Study: PHC Tests of Change

Data Findings: PHC discovers that only 50% of their African - American patients and 60% of Latino patients are undetectable on ARVs, compared to 75% of their White patients

Concrete Aim: Improve the success rate of African - American and Latino patients on ARVs to 75%

Measure: Rate of African - American and Latino patients undetectable on ARVs increases to at least 75% and gap with White patients decreases to <5%

Changes Tested:

- Adherence counseling provided by peers instead of MD, RN
- Offer written materials for patients that are designed by and for African - American/Latino patients
- Have a staff member explicitly bring up with patients about any concerns regarding different effects of ARVs in different races

Let's check in one last time with The Positive Health Clinic. The PHC quality committee chose three changes to test. The tests included:

- having a peer do adherence counseling instead of a clinical provider
- using educational materials that are specifically targeted for African - American communities
- asking staff to have conversations with patients about their specific concerns about the effects of ARVs on different races

After several PDSA Cycles, the PHC found that having peers provide adherence counseling was most helpful in increasing the ARV success rate of African - American and Latino patients.

Ms. P was trained herself as a peer advocate and now works in the clinic helping other patients be successful with treatment. These are the sort of positive outcomes that you can achieve by incorporating cultural competence into your organization. This real world example shows how we can meet the needs of our patients by incorporating cultural competence into your quality improvement agenda.

Cultural Competence Resources

- Cultural Competence Resources for Healthcare Providers
<http://www.hrsa.gov/servicedelivery/default.htm>
- Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile
<http://www.hrsa.gov/culturalcompetence/indicators/>
- AIDS Education and Training Centers, Guiding Principles for Cultural Competency
<http://www.aidsetc.org>
- A Guide to Addressing Cultural Competence as a Quality Improvement Issue in HIV Care
<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Tools/A/GuidetoAddressingCulturalCompetenceQlinHIVCare.htm>

In this Tutorial we have gone over the basics of what cultural competence and disparities are, why it makes sense to use quality improvement to address cultural competence, and how to get started. Here are some additional resources you can use to build your expertise and the skills of your organization in this critical area.

The Quality Academy



For further information, contact:

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90 Church Street, 13th floor
New York, NY 10007-2919
Work: 212.417.4730
Fax: 212.417.4684

Email: Info@NationalQualityCenter.org

Or visit us online at
NationalQualityCenter.org

This concludes this training session.