
From the Perspective of CEOs: What Motivates Hospitals to Embrace Cultural Competence?

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EXECUTIVE SUMMARY

The quality domains of patient-centered and equitable care are increasingly relevant to today's healthcare leaders as hospitals care for patients with increasingly diverse cultural and linguistic needs. Hospital leaders face substantial tensions in defining their organization's strategic priorities to improve care for diverse populations with limited resources, increased competition, and complex regulatory and accreditation requirements. We sought to understand what motivates hospitals to focus on and commit resources to supporting the delivery of culturally competent care by analyzing interviews with chief executive officers (CEOs) in 60 hospitals across the United States.

Hospital CEOs in our study most often embraced cultural competence efforts because doing so helped them achieve the organization's mission and priorities and/or meet the needs of a particular patient population. Less often, they were motivated by perceived benefits and legal or regulatory issues. Many CEOs articulated a link between quality and cultural competence, and a smaller number went on to link cultural competence efforts to improved financial outcomes through cost savings, increased market share, and improved efficiency of care. However, the link between quality and cultural competence is still in the early stages. Fortunately, frameworks for hospitals to adopt and steps that hospitals can take to improve the quality of care for all patients have been identified. They begin with a commitment from hospital leaders based on understanding the needs of patients and communities and are propelled by data that reveal the impact of efforts to improve care. Leaders must communicate and shepherd organizations to align the congruence between improvement efforts and business strategies.

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BACKGROUND

Patient-centered and equitable care are two of the six domains of high-quality healthcare identified by the Institute of Medicine in its influential report *Crossing the Quality Chasm* (Institute of Medicine 2001). These domains are of increasing importance as rapid demographic changes in the United States result in greater numbers of patients with diverse cultural backgrounds and limited English proficiency (LEP) (U.S. Census Bureau 2008). These demographic changes also have implications for the quality of healthcare delivered given that language and cultural barriers affect the quality of care (Baker, Hayes, and Fortier 1998; Institute of Medicine 2004; Karliner et al. 2007) and increase the likelihood of medical errors (Flores et al. 2003). One approach, then, for improving care for diverse populations is to provide culturally competent care, which is responsive to cultural and linguistic needs of patients (Betancourt et al. 2003; Brach and Fraser 2002; Lipson and Dribble 2005).

A 2006 national survey found that 80 percent of hospitals frequently encountered patients with LEP (Hasnain-Wynia et al. 2006). For these organizations, the challenges of meeting the cultural and linguistic needs of patients intersect with their efforts to improve the quality of care delivered in hospital settings. Thus, today's hospital leaders face substantial tensions in defining their organization's strategic priorities to improve care for changing populations with limited resources, a diverse workforce, increased competition, and complex regulatory and accreditation requirements. Little is

known about the perspectives of healthcare leaders in balancing these tensions. We sought to build on the knowledge that organizational responsiveness to external environments is driven by leaders (Dansky et al. 2003) by uncovering what motivates hospital leaders to focus on and commit resources to support the delivery of culturally competent care by analyzing interviews with chief executive officers (CEOs) in 60 hospitals across the United States.

METHODS

The data for this analysis are derived from a study conducted by The Joint Commission to examine the provision of culturally and linguistically appropriate care in U.S. hospitals. The *Hospitals, Language, and Culture* (HLC) study methods have been previously detailed (Wilson-Stronks and Galvez 2007; available at www.jointcommission.org/patientsafety/hlc). Briefly, 59 hospitals were recruited using a purposive approach to include hospitals of varying size, geographic location, and teaching and ownership status (see Table 1). The judgment sample hospitals ($n = 29$) were selected because they had demonstrated efforts to provide culturally and linguistically competent services. The stratified sample ($n = 30$) hospitals comprised a comparison group of hospitals randomly drawn from geographically and demographically diverse national samples using U.S. Census Bureau and American Hospital Association data (Wilson-Stronks and Galvez 2007).

This study was approved by The Joint Commission's contracted institutional review board (IRB), Independent Review Consulting, Inc., and

TABLE 1

Select Characteristics of Hospitals in *Hospitals, Language, and Culture Study*

	Judgment N = 29*	Stratified N = 30	Total N = 59
Region			
Northeast	6	4	10
Midwest	8	4	12
South	7	9	16
West	8	13	21
Locale			
Rural	3	12	15
Semirural	4	5	9
Urban	22	13	35
Hospital size (beds)			
Small (25-100)	1	10	11
Medium (101-299)	5	11	16
Large (300+)	23	9	32
Teaching status of hospital			
Teaching	18	4	22
Non-teaching	11	26	37
Ownership			
Private	21	23	44
Public	8	7	15
Years in current position for CEO (average)	5.09 years ^a	6.38 years ^b	5.75 years

*One judgment sample site did not complete a CEO interview.

^aTwenty-four of 29 survey participants responded.

^bTwenty-three of 30 survey participants responded.

IRBs at several participating hospitals. Between September 2005 and March 2006, study personnel conducted site visits to all 60 hospitals. During these visits, a trained researcher audiotaped 60-minute, in-depth, semistructured interviews with hospital CEOs. The interview focused on (1) changes in the patient population and organizational response to these changes; (2) challenges to providing care to diverse

populations; (3) locus of organizational responsibility for cultural competence; (4) linkages, if any, between cultural competence and other organizational initiatives (e.g., quality improvement); (5) the governing board's interest and priorities related to cultural competence; (6) how cultural competence is addressed in organizational strategy and financing; and (7) consequences of providing culturally competent care. The

full interview protocol is available at www.jointcommission.org/patient-safety/hlc. Fifty-nine interviews were completed. Audiotapes were transcribed verbatim, resulting in 511 pages of interviews.

ANALYSIS

Each author independently reviewed ten transcripts through multiple readings using grounded theory (Strauss and Corbin 1998) to identify themes and categories of responses to questions. Key words, phrases, and concepts were highlighted to distinguish major ideas. We used constant comparison, content, and thematic analysis to identify and code frequently expressed ideas to support the systematic discovery of theory from the data (Miles and Huberman 1984; Patton 1990). There were no a priori codes; all themes emerged through the process of transcript analysis. We then compared the independently identified themes to verify and clarify themes until we achieved consensus on the final coding scheme. Following this step, each author independently coded all 59 interviews using the coding scheme. Test-retest checks were conducted throughout to assess coding reliability. In addition, codes were compared for all interviews; discrepancies were resolved by discussion. Data were managed using the QSR NVIVO 2.0 software (QSR International, Melbourne, Australia). The final step in the analysis was to focus on the codes that explained CEOs' motivations to embrace culturally competent care. We used the method of constant comparison to refine these codes and to discern subcategories and determine the interrelationships, if any,

among the various codes. We report the results by describing the most frequently ascertained themes and providing the number of interviews in which the themes were identified, regardless of how often they were mentioned during the interview. Verbatim quotes are used to illustrate the themes.

RESULTS

Table 1 summarizes key characteristics of the 59 hospitals in this study. The sites were located throughout the United States, with a larger representation of hospitals in western and southern states in urban settings. More than half of the hospitals had greater than 300 beds and were not teaching facilities. Nearly 75 percent of hospitals were privately owned. On average, CEOs had held their leadership position for six years. In the following sections, we describe five common themes that emerged from the CEO interviews as reasons for embracing cultural competence: alignment with mission and strategic plans, meeting patients' needs, perceived benefits of embracing cultural competence, laws and regulations, and using external funds to support cultural competence activities.

Alignment with Mission and Strategic Plans

The most frequent motivation cited by CEOs for embracing cultural competence efforts was that doing so was aligned with realizing the organization's mission or strategic plans (49 of 59, or 83 percent). CEOs from the judgment sample were more likely to report this alignment than were those in the stratified sample (28 versus 21; see Table 2).

TABLE 2
Factors Motivating CEOs to Embrace Cultural Competence

Motivating Factor	Judgment N = 29	Stratified N = 30	Total N = 59
Alignment with priority and mission	28	21	49
Meet patient needs	20	20	40
Perception of benefit	21	15	36
Law and regulation	14	17	31
External funding	5	13	18

In some cases, activities that advanced the delivery of cultural competence were explicitly integrated into the hospital's strategic plan. One CEO reported: "if you look at our three-year strategic plan the focus is on . . . the Amish population and making sure that we understand what their desires are, if we can help them begin to look at us as the provider of care. . . ." His organization worked to understand this population's cultural perspectives on health insurance and billing services and their desired access to specific services. It responded by redesigning billing and maternity services to increase the likelihood that the hospital would be the provider of choice for the Amish community. Another CEO described how planning for a new hospital incorporated an understanding of the culture of the Native American population it would serve: "Well, we felt the need, in designing the layout [of the new hospital] . . . to incorporate the culture elements that are important, such as the four directions [cardinal directions important in the spiritual tradition]."

CEOs also emphasized that they embraced cultural competence efforts

because doing so was consistent with their mission or, as one leader put it, "it is part of why we exist." Another voiced, "What really is driving us . . . is who we serve in this valley. In the 8,000 square miles there are two critical access hospitals that are very small, very modest hospitals. But we are the only place that provides OB [obstetrics] and surgery, intensive care, rehab, and on and on. For the folks [who] live here, we are it. So we take that very seriously. That is our responsibility. And we need to serve them better, and we are out there. It is our mission." This hospital's cultural competence efforts focused on improving diabetes care by engaging the community through focus groups, improving outreach by using community health workers or *promotores*, and educating clinicians about community outcomes for diabetes.

Meeting Patients' Needs

Another important motivation for embracing cultural competence was a desire to meet patients' needs (cited by 40 of 59 respondents, or 68 percent), which did not differ in importance for CEOs in the judgment and stratified

samples. Leaders noted that to meet patients' needs it was essential to understand their perspectives of care. One CEO said, "What drives me is the quality of the patient care we provide insofar as you have to understand the patients' needs, wants, and desires and they need to understand what it is you're doing for them or what their options are. . . . You can't do that without understanding their culture and communicating with them as effectively as possible." This hospital's efforts included recruiting Spanish-speaking staff, expanding interpretation services, conducting staff training in cultural competence, and improving cancer screening by addressing cultural barriers to preventive care among Asian populations.

To meet needs, some hospitals proactively elicited information from patients and communities through surveys, focus groups, and interviews and used this information to design services. Other ways of identifying needs included reviewing community public health data and questioning hospital staff. One leader explained how staff brought the need for increased efforts in cultural competence to the attention of hospital leadership, "I took my job in 1998, and one of the things that people wanted to tell me right away is, 'I'm not sure we're fully honoring our diverse population. . . .' And these were among staff nurses and environmental service folks. You know it wasn't that they felt deprived, it was they wanted to make sure that . . . [patients' needs were met]."

The types of patient needs that were identified included accommodations for spiritual practices, dietary requirements, language barriers, and cultural

norms such as including multiple family members in the care processes. A CEO noted that meeting needs can be costly, as in the case of interpreter services, but doing so is a necessity: "I know that [our hospital] has contracted with the interpreter line, which is a fairly expensive thing, but again, I think those are just the ongoing costs of trying to meet the needs of your patients, so we don't view it as expending additional fiscal resources, it's what's necessary to try to meet the needs of our patients." Another CEO underscored the link between meeting patient needs and delivering quality care: "If you can't communicate with the individual, then, odds are, something is going to be missed and they are not going to get the right care or be compliant with the regimen, which means they'll end up back here at the hospital, so I think it is the right thing to do if you want to ensure the highest quality care for everyone coming into the institution."

Perceived Benefits of Embracing Cultural Competence

The next most cited reason by CEOs (36 of 59, or 61 percent) for embracing cultural competence was the perceived benefits resulting from these efforts. CEOs from the judgment sample were more likely to identify this motivator than were those in the stratified sample (21 versus 15; see Table 2). In addition to improved quality of care, CEOs described increased market share, cost savings, and improved work environments. These benefits were not mutually exclusive. Leaders gave examples of improved care resulting from improved communication, with one CEO stating,

"We in this community compare mortality stats, and it turns out you can keep people alive better if you can talk to them!" Another echoed this sentiment: "When you can communicate with someone, really communicate with someone, and they understand what their role and our role is in their care, I think it improves their outcomes. All the safety literature proves that as well."

Discussions of improved quality of care frequently touched on cost savings. For example, a CEO described how the hospital discovered that Latino mothers were making frequent emergency department (ED) visits for their children's earaches because they did not understand how to take the children's temperature. The hospital's response was to develop kits that included a thermometer and easy-to-follow instructions. He noted, "Instead of spending \$400 an hour [in the ED] we give them a \$3 kit."

Another CEO detailed how her organization's effort to create services for largely homeless and minority populations of intravenous drug users with soft tissue infections led to improved care and increased market share. Before the organization undertook changes, these patients would wait in the ED until an operating room was available for them to undergo drainage and then be admitted for a "two-week hospital stay for antibiotics, which was very expensive." To improve this situation, the organization "got our substance abuse, surgeons, and ED folks together to find out how we can provide care better to this group [because] we're missing this cultural climate. . . . We created wraparound service for [the patients]—we have

counseling and can get them hooked in with social workers, counselors, methadone slots; we have a clinic for wound care and abscess draining and antibiotic therapy daily. You talk about market share—all we did was open the clinic—didn't send flyers or do postings at shelters—we were never at a loss for people coming in." This CEO noted that the hospital's efforts also resulted in cost savings and improved patient satisfaction. She summarized, "When you do cultural competency right, you can save money. You need to know how to do it right."

In most cases the benefits of embracing cultural competence were not quantified or perhaps even quantifiable. One CEO remarked, "The way [that cultural competence] should help us—though I don't have the evidence—is length of stay. Our length of stay is going down, but is our ability to communicate with patients helping this? I don't know. I don't have a way to measure. I can say that we have spent [lots of money on this] and we are not worse off for having spent this money." Another noted, "I can't tell [what the fiscal impact of cultural competence] has been . . . other than we're very busy and our performance is going up as we put more effort into this. Our financial performance is getting better. I'm not telling you whether it's because of that, but it certainly hasn't gone down as we expend more effort into this area." Another CEO echoed, "It is hard to quantify everything. There are the direct costs . . . but also, the costs that are hard to measure . . . [such as the] cost of delays in care because of a language barrier."

Laws and Regulations

Despite a common perception that regulation is the only way to engage leaders, CEOs were infrequently motivated to embrace cultural competence for regulatory or legal reasons. Approximately one-half of CEOs (31 of 59) indicated that their cultural competence efforts were motivated by law and regulation. Judgment sample CEOs were less likely to report this motivator than were those in the stratified sample (14 versus 17). Only a few could cite a specific example or indicate detailed knowledge of such regulations. In fact, most CEOs were unaware of existing regulatory requirements for the provision of language access services. A typical response was, "I know that we have to provide a mechanism for communication. Maybe it is not legal or regulatory; it might be accreditation."

CEOs acknowledged that law and regulation helped focus priorities, but they often found other factors more compelling, as noted by a CEO who said, "We have gone beyond what the laws [are] to embrace it [cultural competence] as a business strategy." He went on to explain that the decision was driven by the organization's desire to "be attractive to patients and try to increase market share and make this an institution that they look to, to provide care." To accomplish this, the organization invested substantial effort and resources into workforce recruitment and training as well as interpreter and dietary services for local communities that included Chinese, Orthodox Jewish, Latino, and Arabic populations. Interestingly, only three CEOs reported that lawsuits motivated their organization's cultural competence efforts. Each went

on to state that the legal action ultimately improved their language services.

Using External Funds to Support Cultural Competence Activities

Less than one-third of CEOs (18 of 59) reported that external funds played a key role in their organization's decision to embrace cultural competence. Interestingly, only five of these respondents were in the judgment sample. The funds, often in the form of grants, were used to improve chronic disease care, provide clinical services and patient education, improve access to care, train staff, and offset infrastructure costs for improving interpreter services. A CEO remarked, "The way we are able to do a lot of our [cultural competence activities] is through the funds of private philanthropists."

DISCUSSION

Hospital CEOs in our study most often embraced cultural competence efforts because doing so helped them achieve the organization's mission and priorities and/or meet the needs of a particular patient population. Less often, they were motivated by perceived benefits and legal or regulatory issues. The last is not surprising given the limited number of national or state regulations in this arena beyond those focusing on access to medical interpreters. While The Joint Commission has some standards that support the provision of culturally competent care (The Joint Commission 2009), they tend not to be prescriptive, which may help explain why they are not an important motivator for hospital leaders. With the exception of interpreter services, the range of approaches and activities reported by

CEOs underscores that when it comes to delivering care responsive to cultural and linguistic needs of patients, "one size may not fit all" (Wilson-Stronks et al. 2008).

We expected to see more differences in the factors that motivate the two samples of hospital leaders, reflecting a greater awareness of and interest in cultural competence among judgment-sample respondents. The largest difference was the role external funding played for stratified-sample CEOs, which suggests that external motivators can stimulate cultural competence initiatives for organizations at an earlier stage of commitment to culturally competent care. One explanation for the lack of difference between the two samples may reflect the fact that CEOs in the stratified sample were running hospitals in racially, ethnically, and linguistically diverse areas. In this respect, it could be stated that cultural competence is a necessary consideration for serving a diverse population.

A national survey of hospital CEOs found that their first two concerns are clinical and financial outcomes; diversity issues ranked as number twelve of fifteen critical focus areas for organization success (Cejka Search and Solucient LLC 2005). However, the inextricable link between quality of care and racial, ethnic, and linguistic diversity is well documented (Karliner et al. 2007; Newman Giger and Davidhizar 2007; Smedley, Stith, and Nelson 2003), making diversity and cultural competence efforts highly relevant for all leaders interested in improving clinical outcomes and patient safety. Some CEOs in our study articulated this understanding, and a smaller number went on to link

cultural competence efforts to improved financial outcomes through cost savings, increased market share, and improved efficiency of care. Overall, the understanding of the linkage between quality care and cultural competence remains in an early stage for several reasons. First, awareness is limited of the intersection between quality of care, healthcare disparities, and cultural competence. And many leaders believe that they already provide high-quality health-care to all their patients regardless of race, ethnicity, or language (Siegel et al. 2007). Next, most organizations do not stratify quality outcomes by sociodemographic characteristics (e.g., race, ethnicity, preferred language, education level), which could help uncover local health disparities. In addition, a lack of recognition of existing laws and regulations for language services may also contribute to inequity in care through limited access or underutilization of language services (Hasnain-Wynia et al. 2006). Finally, knowledge is limited about effective interventions and strategies for tailoring care to improve equitable health outcomes. Fortunately, frameworks for hospitals to adopt and steps that hospitals can take have been identified to begin to improve the quality of care for all patients, including those most vulnerable to disparities (American Medical Association 2006; Karliner and Mutha 2010; Martinez et al. 2003; Smedley et al. 2003; United States Department of Health and Human Services Office for Civil Rights 2003; Wilson-Stronks and Galvez 2007; Wilson-Stronks et al. 2008). While "no checklist of concrete behaviorally based performance indicators can ever fully capture the essence of diversity

leadership" (Dreachslin 1999), a few guiding principles, detailed in the following sections, can be used by leaders to focus cultural competence efforts in a meaningful manner.

Know Your Customer

To provide high-quality and equitable care, hospitals need to know whom they serve and tailor their clinical and administrative services to meet the needs of patients and communities. We echo the recommendations of the Institute of Medicine, National Quality Forum, National Committee for Quality Assurance, and The Joint Commission that organizations systematically collect uniform data on patients' race, ethnicity, and language needs (Institute of Medicine 2009; National Quality Forum 2009; The Joint Commission 2009, 2010; Wilson-Stronks and Galvez 2007; Wilson-Stronks et al. 2008). These data are essential to effectively plan for, provide, and monitor services. Other well-established methods for identifying community needs include using public health data and engaging patients, community leaders, lay health workers, and key social institutions (e.g., churches, ethnic media) in ongoing dialogs to identify health needs as well as provide insight in planning, delivering, and evaluating health services (Tripp-Reimer et al. 2001).

Plan for and Study Improvement

Awareness and knowledge of the populations served can inform strategies for improving the quality of care. For example, knowledge of a community can inform the location of services and hours of operation to improve access,

efficiency, and continuity. This information can also guide staff hiring (e.g., bilingual, bicultural staff), the use of lay health workers to improve chronic disease care education and training for staff and patients (Tripp-Reimer et al. 2001), and the use of language services to improve communication. Once such changes are in place, ongoing monitoring and evaluation is required to assess their impact on the quality of care. Hospital CEOs can ensure that the journey begins and stays on course by building commitment and accountability (Jayne and Dipboye 2004) by working with clinicians and communities to establish metrics for successful outcomes and putting in place quality improvement monitoring systems. The effort must include a commitment to monitoring the effect of improvements on healthcare disparities. This crucial step is facilitated by recent advances in health information technology and effective methods for stratifying, analyzing, and using performance data (Cummings et al. 2008; Weinick, Flaherty, and Bristol 2008). They allow organizations to use data, not intuition, to assess what works and what does not and to contribute to improving care by sharing their learning with others. Such efforts will bring healthcare closer to achieving national goals for reducing healthcare disparities (Healthy People 2010). Additional research is needed to demonstrate the effect of quality improvement efforts on healthcare disparities.

Make It a Business Priority

Cultural competence efforts can reinforce hospitals' mission, facilitate achieving strategic priorities such as

expanding market reach, help institutions improve patient and employee satisfaction, and, most important, improve the quality of care. Integrating cultural competence into organizational priorities and processes requires commitment, determination, and resources. Leaders play an important role in transforming organizations through specific actions (Dansky et al. 2003; Kochan et al. 2003; Kotter 1995; Reeleder et al. 2006). First, leaders need to communicate the organization's vision and priorities regarding culturally competent care within and outside the organization. This communication helps to set priorities based on knowledge of communities served and local health disparities data, and it enables alignment with strategic goals. Next, leaders can assemble a high-level group to lead and take responsibility for the hospital's cultural competence efforts. This group can oversee the creation of effective systems, policies, and interventions to support ongoing effort to ensure that care and services are tailored to meet the needs of diverse populations. Finally, leaders must allocate resources—people and money—as both are required to establish an infrastructure to support the delivery of culturally competent services. An important area of future research is to more clearly define and quantify, where possible, the benefits of culturally competent care, as this will help address the business case for cultural competence.

CONCLUSION

Cultural competence is a "journey, not a destination" (Martinez et al., 2003). The journey begins with commitment from hospital leaders that is based on an

understanding of the needs of patients and communities and is propelled by data that reveal the impact of efforts to improve care. The entire initiative requires that leaders communicate and shepherd the organization to align improvement efforts and business strategies. Future research is needed to more clearly define metrics and quantify the benefits of cultural competence so that it may be effectively integrated into hospital quality improvement processes.

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PRACTITIONER APPLICATION

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In my experience as a healthcare executive, I have found that the vast majority of health professionals are passionately committed to improving the health of all people. In today's increasingly diverse society, however, the actualization of our commitment to serve all is becoming more difficult to achieve. Gaps exist in the way people are treated, and these disparities parallel racial and ethnic backgrounds regardless of income.

This study, examining the motivations of CEOs who embrace cultural competence as a strategic priority, comes at an especially opportune time. Patients of minority populations undoubtedly perceive the U.S. healthcare system as serving some members of society extremely well—and serving others without respect for or sensitivity to their needs. Such unintentional intolerance is difficult for health professionals to acknowledge because of their lack of cultural competence, yet it can no longer be ignored or accepted.

More than one-third of the U.S. population belongs to a minority group, according to the U.S. Census Bureau. Even more telling for the future: 47 percent of children under five are from minority families. Likewise, the nation's workforce is becoming more diverse, from 18 percent minority representation in 1980 to an estimated 41 percent by 2030. The most dramatic workforce transformation of the last half century is the progress of women, from 30 percent representation in 1950 to

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