

Unit I

Preparing for the Provision of Culturally Competent Pharmaceutical Care

How Does One Prepare for Culturally Competent Patient Care?

One can apply the statement “preparation is key” to many aspects of life. Preparation can help lead to successful outcomes in the classroom, in one’s career, and in one’s personal life. For healthcare providers, preparation for providing quality care to patients involves not only learning about clinical presentation of disease and its management, but also learning about a patient’s beliefs, values, and culture, and how they can influence the patient’s views on illness and management.

Cultural competency and providing culturally competent care is being emphasized more in the healthcare field. Some may wonder, “How does providing *culturally competent patient care* differ from providing *patient care*?” Indeed there is a difference, and this difference can impact the following:

- How the provider asks questions to gather information
- Who the provider speaks with when conducting a patient interview
- The responses the provider may receive from the patient about the medical condition
- What additional information the provider may view as pertinent when assessing the patient
- What is involved in the treatment plan

Unit I begins to address the aforementioned items. In addition, the unit includes a discussion on why the provision of culturally competent care in the healthcare arena is important. This discussion includes an overview on health disparities, elements of culture, and cultural competency. Finally, this unit will discuss how pharmacists can become culturally competent patient care providers.

Chapter 1

The Case for Culturally Competent Care in Patient Assessment

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LEARNING OBJECTIVES

At the completion of this chapter, the reader should be able to:

1. List factors contributing to health disparities and various initiatives to mitigate their existence.
2. Identify and explain theoretical frameworks of cultural competence.
3. Describe various cultural competence assessment tools.
4. Define culturally competent patient care in terms of pharmacy.
5. Describe areas of the pharmaceutical care process that can be affected by culture.

KEY TERMS

Acculturation

Assimilation

Cultural competence

Cultural humility

Culturally competent patient care

Culturally competent pharmacist patient care

Culture

Health disparities

Health equity

Health literacy

Patient assessment

Pharmaceutical care

Physical assessment

Stereotype

Introduction

The role of the pharmacist has evolved to include services related to the provision of patient care that extends beyond medication dispensing and patient counseling services. In a 2009 survey by Schommer et al., 43% of respondents reported that they were providing patient care services to some degree at their place of employment. Medication therapy management (MTM) services enable the pharmacist to become even more involved in

Table 1-1 Examples of MTM Services

Anticoagulation management	Chronic disease state management
Immunizations	Medication review
	Pharmacotherapy consults

patient care (Table 1-1), thus providing the pharmacist with the opportunity to make an impact on patient health outcomes. Studies such as the Asheville Project, the Diabetes Ten City Challenge, and Project ImPACT: Hyperlipidemia prove that pharmacists can make a significant impact on patient outcomes when they are a part of the medical team (Bunting, 2008; Fera, 2009; Bluml, 2000) (Table 1-2).

The goal for all healthcare providers is to ensure that patients achieve optimal health outcomes; however, not all patients achieve this. Differences in health outcomes or health status between population groups are referred to as healthcare inequalities, or **health disparities** (Smedley, 2003; U.S. Department of Health and Human Services [HHS], 2011; World Health Organization). Health disparities can be observed across different ethnic and cultural groups, genders, ages, socioeconomic statuses, or other social or biological determinants (Institute of Medicine, 2002; Smedley, 2003; SteelFisher, 2004; HHS, 2011) (Table 1-3).

A single explanation for the presence of health disparities does not exist because many factors can contribute to the development of health disparities. Pharmacists, as patient care providers, should be aware of how these contributors can impact how patient care is provided. The Institute of Medicine (IOM) landmark publication, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” (2002) reported contributors to health disparities (Smedley, 2003) (Figure 1-1).

Health disparities:
Differences in disease incidence and/or prevalence among various cultural groups.

Table 1-2 Evidence of Pharmacist Impact on Patient Care Outcomes

Pharmacist Collaborative Services	Impact
Asheville Project	Sustained improvements in blood pressure, LDL, TG, and TC Increase in percentage of patients at blood pressure and LDL goals Reduction in cardiovascular event rate Increase in cardiovascular medication use
Diabetes Ten City Challenge	Reduction in A1C, LDL, and blood pressure Increase in influenza vaccinations, eye exams, and foot exams
Project ImPACT: Hyperlipidemia	Reduction in LDL Increase in HDL High medication compliance rates

LDL = low-density lipoprotein; TG = triglycerides; TC = total cholesterol; HDL = high-density lipoprotein
Data from Bunting BA, Smith BH, Sutherland SE. The Asheville Project: clinical and economic outcomes of a community-based long-term medication therapy management program for hypertension and dyslipidemia. *J Am Pharm Assoc.* 2008; 48:23–31; Fera T, Bluml B, Ellis W. Diabetes ten city challenge: Final economic and clinical results. *J Am Pharm Assoc.* 2009;49:e52–e60; and Bluml BM, McKenney JM, Cziraky MJ. Pharmaceutical care services and results in Project ImPACT: hyperlipidemia. *J Am Pharm Assoc (Wash).* 2000 Mar–Apr;40(2):157–65.

Other factors have also been identified as contributors to healthcare disparities (Table 1-4); for example, access to health insurance has been determined to be a contributing factor (SteelFisher, 2004). The IOM determined that minority patients are disproportionately enrolled in lower-cost insurance plans, if enrolled in an insurance plan at all (Smedley, 2003; Phillips, 2000). These plans tend to place a greater emphasis on cost containments and healthcare expenditures. This has the potential to affect not only access to quality care, but also access to medication for management of disease. Another contributor to health disparities can result from not asking the patient about his or her preferences in regard to healthcare management and treatment. This can result in providers overlooking preferred treatment options, and thus patient nonadherence to treatment recommendations (Smedley, 2003).

Table 1-3 Examples of Health Disparities in U.S. Populations: Healthy People 2020 Findings

Diabetes prevalence rates among American Indians are 2 to 5 times higher than for their white counterparts.

More than 50% of cases of human immunodeficiency virus (HIV) occur in gay or bisexual men, and 45% of newly diagnosed cases occur in African Americans.

African American women are particularly at risk for infertility issues.

Data from Healthy People 2020: Topics and Objectives. U.S. Department of Health and Human Services. <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>. Accessed July 26, 2014.

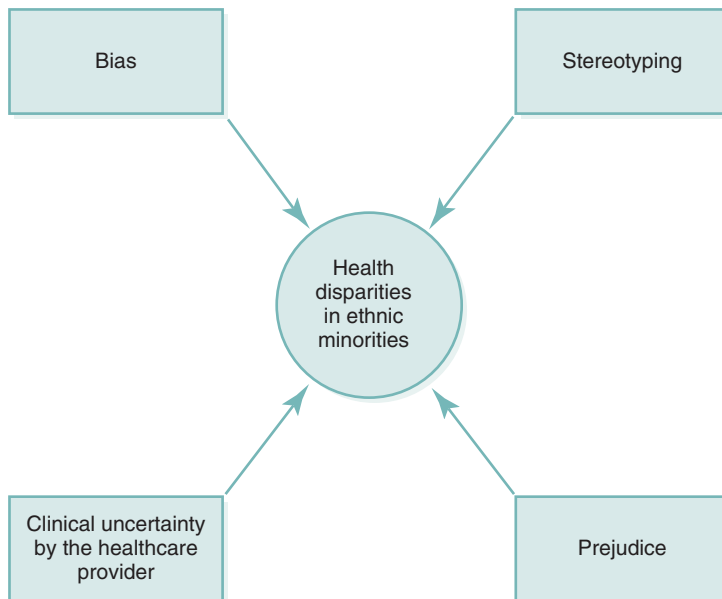


FIGURE 1-1 Contributors to health disparities in ethnic minorities.

Data from Smedley BD, Stith AY, Nelson AR (eds.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2003.

Table 1-4 Examples of Contributing Factors to Health Disparities

Income	Access to Care	Differences in Medical Needs
Socioeconomic status	Insurance Access to transportation Number of healthcare facilities and providers available	Patient preferences Differences in severity of illnesses
Differences in Healthcare Delivery	Language and Cultural Barriers	Provider–Patient Interactions
Fragmentation of healthcare services Provider incentives for cost containment	Language discordance Access to interpretive services Health-seeking behaviors Cultural incongruences	Acceptance of provider recommendations Biases, prejudices, and/or stereotypes Clinical uncertainty Patient mistrust or refusal

Data from Betancourt J, Green A, Carrilo JE. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. The Commonwealth Fund, October 2002; Smedley BD, Stith AY, Nelson AR (eds.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2003; SteelFisher G. *Addressing Unequal Treatment: Disparities in Health Care*. The Commonwealth Fund; November 2004; and Sullivan Commission. *Missing persons: minorities in the health professions: a report of the Sullivan Commission on diversity in the healthcare workforce*. Washington, DC. 2004. Available at <http://www.aacn.nche.edu/media-relations/SullivanReport.pdf>. Accessed July 18, 2013. Adapted from sources: Betancourt; Smedley; SteelFisher; and Sullivan Commission.

Example

It has been documented that pharmacies in minority or low-income neighborhoods stock fewer narcotic and anxiolytic agents in an effort to thwart theft and burglary. How could this practice contribute to a disparity in health care for patients who reside in these communities?

Health equity:
Attainment of the highest level of health for all people (HHS, 2011).

A concerted effort has been made to eliminate health disparities and achieve **health equity**. This effort is multifaceted, targeting many areas of the healthcare system as well as governmental agencies, educational systems, professional organizations, and the healthcare industry. Federal and legislative initiatives, such as the National Standards on Culturally and Linguistically Appropriate Services (CLAS), have helped address some of the factors that contribute to health disparities. CLAS help to ensure that healthcare organizations make healthcare and related services more accessible by offering language assistance services to patients (HHS, 2014). Healthy People 2010, spearheaded by the U.S. Department of Health and Human Services, was developed in 2000 with the primary goals of eliminating health disparities and increasing the quantity and quality of healthy life years nationwide. The Healthy People initiative has continued with the release of Healthy People 2020.

In response to the Sullivan Commission (2004) recommendation for cross-cultural education of healthcare providers, health professions schools, including colleges and schools of pharmacy, have initiated programs and curricula to impact health disparities and promote cross-cultural education (Accreditation Council for Pharmacy Education [ACPE], 2011; Association of American Medical Colleges, 2005; American Association of Colleges of

Nursing, 2008). Implementation of cross-cultural education can help to develop health-care providers who are culturally aware and able to incorporate cultural elements into their patient care practices. The ACPE (2011) standards and guidelines for the professional program in pharmacy leading to the doctor of pharmacy degree now require that “the college or school must ensure that the curriculum addresses patient safety, cultural competence, health literacy, healthcare disparities, and competencies needed to work as a member of or on an interprofessional team” (p. 18). As a result, colleges and schools of pharmacy have incorporated coursework and clinical practice experiences that will help prepare student pharmacists to address health disparities in their careers. Leading pharmacy organizations have also responded to the call to action in regard to eliminating health disparities (ASHP, 2008; American Pharmacists Association, 2013; Vanderpool, 2005). One of the nation’s professional pharmacy organizations, the American Society of Health-Systems Pharmacists (ASHP), developed rationale for the culturally appropriate provision of pharmacy services, stating that pharmacists are positioned to be leaders in this arena.

Pharmacists should be viewed as an effective member of the healthcare team dedicated to eliminating healthcare disparities. Pharmacists have shown that their efforts can make a significant impact on patient care outcomes. Coupled with the curricular changes in pharmacy education as well as the positions taken by influential pharmacy organizations, it is clear that pharmacists are in a key position to help eliminate health disparities and thus achieve health equity. Consequently, it is important for pharmacists to understand and utilize models of **culturally competent patient care**, which has been defined by Betancourt, et al. (2002) as “providing care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.” In order to provide such patient care, one must have an understanding of the concepts related to culture, and how these concepts can be applied to health care and, in particular, pharmacy practice.

Beginning the Journey of Providing Culturally Competent Patient Care

To begin the journey toward providing culturally competent patient care, the pharmacist should first realize that **culture** is not just limited to race and ethnicity. This term encompasses language, values, beliefs, behaviors, and traditions. Cultural identity can be based on a multitude of factors, such as age, gender, area of residence, or religion (Johnson, 2005; Kronish, 2012; Coronado, 2004; Patcher, 1994). Culture can influence a person’s beliefs and actions in regard to when to seek medical treatment, who to seek treatment from, and how medical conditions are viewed and treated. It is important to keep in mind that not all cultural beliefs, values, traditions, or practices are exactly the same for each patient of a particular culture. This is the result of the processes referred to as acculturation and assimilation.

Acculturation is a process in which an individual begins to incorporate some of the beliefs, values, and traditions of other cultures into his or her life. As a result, one must be aware that not all members of a culture will strictly follow the values, beliefs, traditions, and practices endemic to that culture. In some instances people may experience **assimilation** to the primary or mainstream dominant culture; therefore, cultural practices may not be totally reflective of one specific cultural group. It is important to realize that although

Culturally competent patient care:

Care that takes into account social, linguistic, and other individual aspects of the patient.

Culture:

The values, attitudes, beliefs, norms, traditions, language, and so on that are characteristic to a group.

Acculturation:

To adopt or borrow cultural traits or social patterns from another group.

Assimilation:

The process in which an individual or members of a culture come to resemble those of another culture. Full assimilation occurs when new members of the group are indistinguishable from other members of the group.

Stereotype:

A broad generalization, positive or negative, that is associated with a specific group of people.

cultures are unique and vary significantly with respect to values, beliefs, and practices, individuals within the culture are just as unique. Failure of healthcare providers to take this into consideration may allow them to perceive patients as **stereotypes** based on what may be known about some patients' identified ethnic cultural group. Clinical decision making based largely on stereotypes without further inquiry about the individual patient's needs may be detrimental to the pharmacist-patient relationship. Providing patient care based on stereotypes, however, is distinctly different from providing patient care that involves making *informed* decisions rooted in cultural knowledge. For example, it would be important to address known risk factors present in patients of a particular cultural group if those risk factors could potentially lead to poor patient outcomes. Incorporation of this knowledge into one's practice is one of the key elements of reducing health disparities.

Health Literacy**Health literacy:**

The ability of an individual to utilize health-related information to make decisions about their own health and health-related issues.

The U.S. Department of Health and Human Services (2000) defines **health literacy** as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions." At least four sections of the law directly reference interventions to impact health literacy, and another six sections may indirectly affect it (Somers, 2010). Statistically, it has been estimated that 87 million adults in the United States are functionally illiterate, which means they have difficulty with the basic understanding and use of written information. More specifically, only about 12% of American adults have a proficient level of health literacy (Somers, 2010). Health literacy is not just a matter of a patient being able to read or write. A patient needs to be able to read, write, speak, listen, perform mathematical calculations, and understand rhetoric or contextual hints to successfully navigate the healthcare system. Unfortunately, many patients are unable to amalgamate these skills appropriately to receive care. It has been estimated that 9 out of 10 adults are not fully able to use health information that is readily available in healthcare facilities and from providers, as well as the health information in everyday media (HHS, 2010).

Low health literacy can adversely impact different types of people, but it has been shown to disproportionately impact nonwhite ethnicities (including minorities), geriatric patients, those with lower socioeconomic status or education, cognitively impaired patients, non-native English speakers, and/or those with low English proficiency (HHS, 2010). These are similar to populations that have previously been identified as being at risk for health disparities. Therefore, a discussion of health literacy must occur in the course of providing culturally competent care. Cultural or linguistic barriers may be inadvertently placed, prohibiting optimal **patient assessment** and care activities.

Patient**assessment:**

Process used to identify patient problems via evaluation of the patient's subjective reports and objective data.

Health literacy is composed of both individual and systemic factors (**FIGURE 1-2**). Each of those factors contributes to the success of the patient being able to access, receive, and utilize services in the healthcare system. The Centers for Disease Control and Prevention (CDC) has listed the individual factors as literacy skills, health knowledge, demographics/culture, and experience. Each of these determinants is unique to each patient. Systemically, contributory factors are the type of health practice available, the infrastructure of services, and the abilities of the practitioners available to the patient. Practitioners are responsible for the manner of communication and reinforcement that they provide. Increasing the

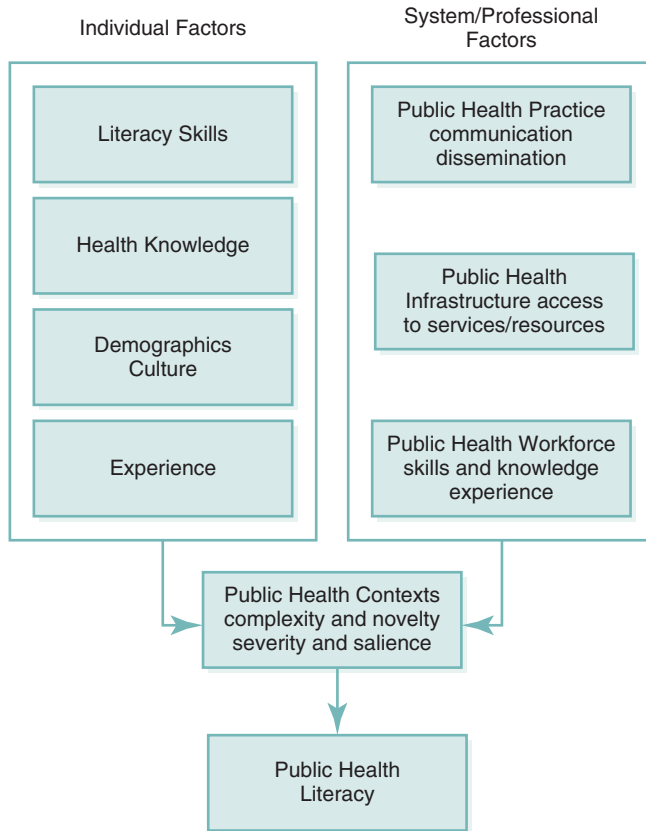


FIGURE 1-2 Factors that affect health literacy.

Reproduced from the Centers for Disease Control and Prevention. Health literacy for public health professionals. Available at: <http://www.cdc.gov/healthliteracy/training/page655.html>. Accessed March 4, 2014.

ease of entry into the healthcare system using simplified forms, unambiguous language, and adequate examples, and probing for understanding are required for the low health literacy patient. Although this brief overview will not review the application of readability scales to patient literature to determine its complexity, the practitioner who is continuously aware that low health literacy is a prevalent issue will interact with a more satisfied, responsive patient. When attempting to develop a successful treatment plan during patient assessment, the practitioner is able to collect more valuable information from a patient who is comfortable and responsive.

Cultural Competence: Definition and Theoretical Frameworks

Recognizing cultural differences is just one part of becoming a culturally competent provider. However, what exactly does it mean to become “culturally competent”? Cross et al. (1989) have defined **cultural competence** as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations.”

Cultural competence:

The ability to provide care that takes into account social, linguistic, and other individual aspects of the patient.

Cross's definition of cultural competence underscores a multilayered approach involving not only individuals, but also the policies, procedures, and systems of an organization that are symbiotically intertwined. O'Connell and colleagues (2009) described several components of a "culturally competent pharmacy practice" including developing strong ties with the community and the continuous assessment of whether a practice is achieving culturally competent care.

The cultural competence process has been described as a continuum that consists of six stages (Table 1-5). Because it is a process, one is always on the path to becoming

Table 1-5 Stages of Cultural Competence

Stage	Definition	Example
Cultural destructiveness	The presence of practices that are harmful to a cultural group	A practitioner may openly discriminate against an individual or a group of individuals of a specific cultural group by refusing to provide care or services (e.g., a pharmacist refuses to offer interpreter or translator services).
Cultural incapacity	Having the inability to respond to the needs, preferences, or practices of culturally diverse groups; may be the result of a lack of resources, cultural bias, or lower expectations of cultures	It is cost prohibitive for a pharmacist/pharmacy to provide and offer interpreter or translator services to ESL (English as a second language) patients.
Cultural blindness	Stems from the belief of treating all people the same; may encourage assimilation rather than recognizing differences	Pharmacy/pharmacist provides patient education to an ESL patient population only in English and doesn't understand the importance of offering interpreter or translator services.
Cultural precompetence	Having an awareness of areas of strength related to culture and areas of needed improvement; has made efforts to incorporate culture into practice	Pharmacy/pharmacist purchases software that enables the staff to provide patient education in other languages.
Cultural competence	Cultural awareness and practices are implemented into the practice structure	Pharmacy/pharmacist provides an array of interpreter or translator services such as hiring bilingual staff.
Cultural proficiency	Integrates culture into the foundation of all practices and decisions	Pharmacy/pharmacist provides an array of interpreter or translator services and continually assesses the effectiveness and impact of services on patient health outcomes and satisfaction.

Data from Cross T, Bazron B, Dennis K, Isaacs M. *Towards a Culturally Competent System of Care*. Vol. 1. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center; 1989.

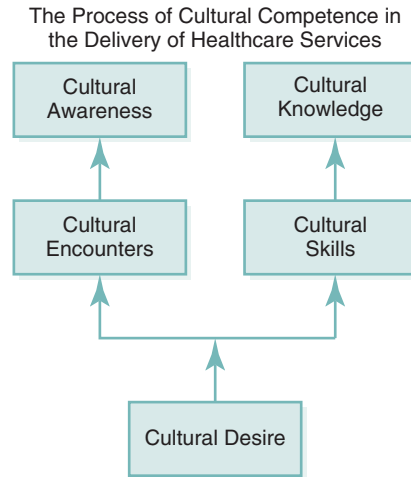


FIGURE 1-3 The process of cultural competence in the delivery of healthcare services.

Reproduced from Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: A model of care. *J Transcult Nurs.* 2002;13:181.

culturally competent and should be cautioned against the belief that one can develop total mastery of cultural competence.

Additionally, in the article “The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care,” Campinha-Bacote (2002) conveys that cultural competence is composed of a number of constructs, principally “cultural desire,” “cultural awareness,” “cultural knowledge,” “cultural skills,” and “cultural encounters” (**FIGURE 1-3**). According to Campinha-Bacote, a healthcare professional on the pathway to becoming culturally competent regularly self-assesses for individual biases and prejudices (*cultural awareness*), possesses the motivation (*cultural desire*) to continually seek relevant knowledge about various cultural groups (*cultural knowledge*), applies that information appropriately in the provision of direct patient care services (*cultural assessment*), and seeks out experiences (*cultural encounters*) that allow the individual to hone his or her skills. Tervalon and Murray-Garcia (2009) particularly underscored the criticality of self-assessing and reflecting on an individual’s cultural identity and the dynamic interplay when interacting with patients as healthcare providers strive for “**cultural humility**.”

Cultural humility:

An individual’s process of self-introspection and reflection in the quest to respect the diverse values, attitudes, beliefs, norms, and traditions of others.

Cultural Competence Assessment Tools

When beginning the journey toward providing culturally competent patient care, it is a good idea to determine the baseline level of cultural competence. A number of assessment tools (**Table 1-6**) have been published to help individuals measure their ability to provide culturally competent care. Given that becoming able to provide culturally competent care is a process involving motivation, introspection, and the attainment of knowledge and skills, assessment is a vital component of this process.

Table 1-6 Cultural Competency Self-Assessment Tools

Competence Assessment Tool	Method	Cost	Tool Location
Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)	Paper-based self-assessment	User fee required	http://www.transculturalcare.net/iapcc-r.htm
Clinical Cultural Competency Questionnaire (CCCQ)	Available online (with explicit author permission)	Free	http://rwjms.rutgers.edu/departments_institutes/family_medicine/chfcd/grants_projects/aetna.html
Cultural Competence Health Practitioner Assessment (CCHPA)	Paper-based self-assessment (with explicit author permission)	Free	http://nccc.georgetown.edu/features/CCHPA.html
Quality and Culture Quiz	Available online	Free	http://erc.msh.org/mainpage.cfm?file=3.0.htm&module=provider

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised

The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R), developed in 2002 by Campinha-Bacote, measures the ability of both practitioners and students in medicine and allied health sciences to provide culturally competent care (Transcultural Care Associates, 2002). Administered as a paper-based self-assessment, the IAPCC-R consists of 25 items measuring the cultural competency constructs of desire, awareness, knowledge, skill, and encounters. The estimated completion time is approximately 15 minutes. It utilizes Likert scales to measure responses to the items. The inventory requires author permission and submission of a user fee.

Clinical Cultural Competency Questionnaire

The Clinical Cultural Competency Questionnaire (CCCQ) is a self-assessment tool developed by the Center for Healthy Families and Cultural Diversity, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School. The CCCQ was initially developed to specifically measure knowledge, skills, comfort level of encounters/situations, and attitudes of physicians providing care to diverse patient populations in conjunction with a cultural competency training program. The CCCQ is a free tool that can be used with explicit permission of the authors. It is a paper-based self-assessment consisting of approximately 75 items.

The CCCQ, with modifications, may be useful to both pharmacy students and pharmacists. For example, Okoro and colleagues (2012) specifically altered the CCCQ to measure the level of clinical cultural competency and health disparities knowledge in

third-year PharmD students; consequently, information gathered from the CCCQ also revealed curricular insight as it related to cultural competency content.

Cultural Competence Health Practitioner Assessment

The Cultural Competence Health Practitioner Assessment (CCHPA) was developed by the National Center for Cultural Competence at Georgetown University and is an exclusively online self-assessment tool with the purpose of enhancing the delivery of services to culturally and linguistically diverse communities. The CCHPA completion time is about 20 minutes, and it addresses the constructs of values and belief systems, cultural aspects of epidemiology, clinical decision making, life cycle events, cross-cultural communication, and empowerment/health management. Depending on the responses, results of the CCHPA will characterize “awareness,” “knowledge,” or “skill” level for each construct. Participants are also provided with a listing of resources (such as web-based journals, textbooks, etc.) to help support ongoing development in those areas.

The CCHPA may be particularly useful for practitioners who want to assess their provision of culturally competent care to a specific ethnic or cultural group. If participants want to assess multiple groups, the CCHPA should be completed for each individual group. The CCHPA is available at no cost to the participant.

Quality and Culture Quiz

The Providers Guide to Quality and Culture, a joint project of the Management Sciences for Health (MSH) and various agencies of the U.S. Department of Health and Human Services can be utilized by both students and practitioners to obtain information on cultural competency and health disparities. Specifically, the Quality and Culture Quiz contains 23 multiple choice and true/false questions that explore content related to topics such as common beliefs/cultural practices, patient adherence, prejudices, and working with an interpreter.

The Quality and Culture Quiz, available online and at no cost to the participant, can be self-administered both online and via a paper-based format. After completion of the quiz, the answers are provided to the participants with a detailed explanation that includes relevant background information to support the correct answer. A high correct score doesn't necessarily denote mastery, but scores should be used to identify areas of strength and those needing improvement in the continuum of an individual's ability to provide culturally competent care. The Quality and Culture Quiz may be useful for pharmacy students and pharmacists alike.

Use of the cultural competence assessment tools such as those listed here provide a starting step toward incorporating cultural competency into the pharmacist practice. These tools will help to serve as a guide for the pharmacist in determining areas related to cultural awareness, knowledge, and skills that are on target and those that need improvement. Pharmacists can reassess their level of cultural competence using these tools as they move toward becoming more culturally competent.

Culturally Competent Pharmacist Patient Care

A definition for culturally competent pharmacist patient care can be developed by merging the definitions for cultural competence by Betancourt (2002) and **pharmaceutical care** defined by the American Society of Health Systems Pharmacists (2003) from an adaptation

Pharmaceutical care:

The provision of care that optimizes health outcomes primarily through the use of pharmaceutical agents.

Culturally competent pharmacist patient care:

The ability to provide appropriate pharmacotherapy treatment that takes into account social, linguistic, and other individual aspects of the patient.

Physical assessment:

Examination of the body from head to toe using observation, palpation, percussion, and auscultation.

of the definition from Hepler and Strand (1990), as “the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient’s quality of life.” Thus, **culturally competent pharmacist patient care** can be described as the direct, responsible provision of medication-related care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural and linguistic needs, for the purpose of achieving definite outcomes that improve a patient’s quality of life. The remainder of the chapter will provide an overview of how culture can be incorporated into each step of the patient care process.

Information Gathering

Gathering patient-related information is one of the beginning steps in the pharmaceutical care process. Gathering information can be achieved by reviewing the patient’s chart, interviewing the patient, and performing **physical assessments**. These steps can allow the pharmacist to better identify the presence or absence of drug-related problems and assess drug therapy outcomes.

Viewing the patient’s chart will provide the clinician with not only demographic information, but also information regarding current and past medical conditions, medication history, response to therapies, and patient needs. During the patient interview, sources of information about the patient will include the patient and/or the patient’s caregivers and loved ones. The pharmacist will be able to obtain subjective information regarding the patient’s current disease state, self-care management of the disease state, and medication adherence and medication-related problems. Performing a physical assessment will provide the pharmacist with the opportunity to gather objective patient data. These data are helpful in determining the extent of disease state control, response to treatment, and the presence of drug-related problems.

Cultural Considerations: Information Gathering

During the information gathering process, finding cultural information in the patient’s chart can be valuable. The patient’s chart can provide some insight regarding the patient’s anticipated needs, such as communication needs, the language preferred to be spoken when discussing healthcare issues, and the patient’s race and ethnicity. Some charts may also include information about the patient’s gender, sexual identity, or religious practices, which could be helpful when formulating a care plan for the patient. Information such as the patient’s communication needs, race, and ethnicity is now required to be in patient charts by some accrediting bodies (The Joint Commission, 2010). Knowing the patient’s communication needs in advance of the patient visit and addressing those needs will allow more information gathering during the patient interview and will reduce the chances of communication errors, which could lead to drug-related errors (Divi, 2007). Being aware of the patient’s race and ethnicity prior to the visit will aid in making informed decisions about how to address risk factors and/or health disparities reported in those particular groups. With this information, the pharmacist can create a patient-specific care plan that addresses the patient’s needs.

Certainly addressing the language needs of the patient will be imperative for the patient interview; however, other cultural considerations also should be noted during the interview process. In addition to language differences, cultural nuances related to the use of verbal and

nonverbal communication can affect how information sought or provided is interpreted by either party. Cultural beliefs regarding who makes health-related decisions may affect who is responding to the information-gathering questions (Institute for Safe Medication Practices, 2003; EuroMed Info; Blackhall, 1995). Finally, cultural views on disease development, health-seeking practices, and origins of illness may be misinterpreted or unintentionally ignored, thus again affecting the patient–pharmacist relationship and ultimately treatment outcomes. To help overcome this, the pharmacist may need to utilize a different series of open-ended questions to gather more information for a better understanding.

Although the physical assessment performed by the pharmacist is pretty limited compared to what is performed by other healthcare professionals, awareness of the cultural implications is still important. In some cultures modesty is highly regarded, which may result in requests for examinations being performed by providers of the same gender (Carteret, 2011).

Identification of Drug-Related Problems

Findings from the information-gathering step of the process should aid in the evaluation for the presence or absence of a drug-related problem (DRP). DRPs have been classified into the categories shown in **Table 1-7**.

Table 1-7 Drug-Related Problems

Untreated indication	Improper drug selection
Subtherapeutic dose	Failure to receive medication
Suprathematic dose	Adverse drug reaction
Drug interaction	Medication use without indication

Data from American Society of Hospital Pharmacists. ASHP statement on pharmaceutical care. *Am J Hosp Pharm.* 1993; 50:1720–3; Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. *Am J Hosp Pharm.* 1990; 47:533–543.

Cultural Considerations: Identification of a Drug-Related Problem

Culture plays a role in the identification of a drug-related problem as well as the reason for the drug-related problem. As an example, an untreated indication may be due to the patient not believing that the condition needs to be treated with medication, and as a result, the patient chooses to not take the prescribed medication. The decision to use an herbal product rather than the medication prescribed by the physician may result in the drug-related problem of a subtherapeutic dose if the patient didn't tell the healthcare provider that they were using herbal products rather than taking the prescription drug. In this case, the provider may have created a plan that consisted of continuous dose escalations and possibly the addition of more medications.

Formulating a Plan

The medication-related aspects of developing a pharmaceutical care plan involve evaluating the need for medication therapy and developing a safe, appropriate, and effective medication plan for a patient. It also includes the provision of medication education to the patient in the form of patient counseling and establishing an appropriate follow-up and monitoring plan to ensure efficacy of the plan.

Cultural Considerations: Formulating a Plan

Creating a drug therapy plan and execution of the plan can be impacted by culture. Although the focus of this text is not on drug selection based on cultural pharmacogenomic variances, it is important to note that drug selection may be guided by cultural or ethnic differences. The creation and execution of the plan can be impacted in other ways. A patient's cultural or spiritual beliefs can impact whether a patient believes he or she needs medication for a certain illness, which can affect adherence to medications (Kretchy, 2013). If the pharmacist believes that the patient needs a medication, yet the patient does not, it may lead to a cultural impasse that can hinder the ability to achieve effective patient outcomes. These are just a few examples of what should be considered when creating and executing the drug therapy plan; failure to address these issues, and those that are similar, can affect patient outcomes.

Summary

This chapter has highlighted the need to provide culturally competent care as one strategy to mitigate health disparities. The relationship between culture and the pharmaceutical care process was explored in terms of how pharmacists can specifically provide culturally competent pharmacist patient care, because culture can have an impact on each step of the process. Additionally, the theoretical frameworks and assessment tools provide the reader with guidance to assist in the overall development of becoming a culturally competent provider.

As a member of the healthcare team, pharmacists have a responsibility to provide care to patients that is designed to ensure positive outcomes for all patients. Incorporating the patient's cultural beliefs and needs is key in this process.

Review Questions

1. In "The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care," Campinha-Bacote describes that cultural competence is composed of a number of constructs. What actions and/or behaviors would an individual display in the "cultural desire" construct?
2. YL is a 50-year-old man who presents to the pharmacy with a prescription for lisinopril, an antihypertensive agent. You look in YL's profile and see that he was prescribed this medication 6 months ago, and again 2 months ago, but he never picked up the medication. Today you notice that the medication dose has been increased. YL speaks very little English, and you do not speak French, which is his preferred language, as listed in his profile. Via an interpreter, you learn that YL stopped taking the lisinopril after 1 week of taking it because he "felt that he didn't have high blood pressure anymore." He did not tell the doctor this because he did not want to disrespect him. Using the interpreter, you were able to speak to YL more about hypertension and treatment. You also inquired more about his beliefs, and what he thought about treating his hypertension. In the end, YL agreed to take the antihypertensive medication. You then called

the physician, explained your findings, and suggested that the lisinopril dose be reduced to a lower dose.

Explain how culture influenced each part of the patient care process in this scenario.

3. JP, a 46-year-old woman, arrives to the clinic for a glucometer teaching and medication review. Prior to starting the visit, what types of information would you look for in her chart to help plan for a culturally competent patient visit? Explain your rationale for your answer.
4. JP returns to the clinic 2 weeks later with a blood glucose log. You see that her blood sugars have been really low. You are concerned about hypoglycemia, and therefore you recommend to her physician to reduce her insulin dose. The physician agrees, and reduces the dose. While explaining to JP the new dose, she explains to you that she is participating in a 21-day fast with her church, in which she has had to eliminate meats and bread from her diet; she eats only fruits and vegetables, and drinks water. How would the patient care process have been affected had JP not shared the information regarding the fast with you? Why?

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