Chapter 7

The Culturally Adaptive Care Model

A Project ECHO Case Study

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Dr. Sanjeev Arora, a Hepatitis C specialist at the University of New Mexico Health Sciences Center, walked into his clinic to find a forty-three-year-old woman with Hepatitis C seeking treatment for the first time after her initial diagnosis eight years earlier. When asked why she delayed treatment, she said she could not afford to take time off work to make the five-hour trip to Albuquerque. She finally sought help when her abdominal pain began interfering with her ability to work. Now it was too late. The untreated Hepatitis C had caused advanced liver cancer that was not suited for surgery or liver transplantation. Guidelines and medicine to treat this patient's illness were available, but the doctor in her rural community did not have the expertise required to treat her disease. She died six months later (Arora 2018).

Dr. Arora recognized that patients in rural and under-resourced areas lacked access to specialty health care, thereby exasperating healthcare disparities. He reasoned that healthcare providers, especially primary care doctors, could help patients with complex conditions if they had additional support from specialists, such as himself. As a result, he created Extension for Community Healthcare Outcomes (ECHO).

Project ECHO began at the University of New Mexico in 2003. Project ECHO is a telementoring program that connects generalist community providers (participants or spokes) with specialist and multidisciplinary teams (hubs) in real-time collaborative sessions focused on guided and reflective practice. An ECHO session includes a brief didactic and a case discussion and analysis. During the ECHO session, hub and spoke participants exchange experiences, ideas, and recommendations. The knowledge held by specialty care providers moves out to community healthcare providers, where the latter contextualize this knowledge and maximize treatment before a patient needs

to be referred to a specialist, if at all. ECHO allows patients to receive specialized care from their local provider, whom they regularly seek care from and who knows them and the local setting (Larson and Medved 2022). Engagement in ECHO sessions also helps cloistered specialists better understand the nature of everyday practice conditions in communities where migrants typically seek care.

Multiple studies have shown that Project ECHO positively impacts provider learning and disadvantaged patient access to care (e.g., Arora et al. 2011; Su et al. 2018; Dearing et al. 2019). To better understand how this fast-moving model is best organized and implemented, we interviewed medical specialists and implementing staff of sixty-two ECHO programs in the United States and Canada as part of a study supported by the Robert Wood Johnson Foundation. Among other goals, ECHO specialists and staff expressed an interest in reducing health disparities by encouraging culturally compatible practices in health care. During our conversations, several interviewees expressed uncertainty about how to engage in such practices. They asked, "What advice do you have for us? What framework or tools can we use to encourage ECHO participants or spokes to provide care that is culturally compatible with patients?" This was a reasonable and timely question as Project ECHO had rapidly spread to 180 countries where language and value systems differ dramatically.

In response to these questions and seeing an opportunity to impact not just Project ECHO but educational interventions across healthcare environments, we developed the Culturally Adaptive Care Model that can be used to think more holistically about and enhance the effectiveness and quality of care by grounding it in the lived cultural experiences of all participants. Cultural adaptation is defined as "reviewing and changing the structure of a program or practice to more appropriately fit the needs and preferences of a particular cultural group or community" (Booth and Lazear 2015, 1). The Culturally Adaptive Care Model is intended to guide users through a discovery of self and others that can lead to adaptations that make health care more culturally compatible with intended audiences—providers and patients alike.

We begin this chapter by reviewing the link between culture and health. Then, we describe the two broad approaches applied over several decades for providing culturally competent care, beginning with *outward-focused* cultural competence, and followed by *inward-focused* cultural humility. Recognizing the limitations of each approach, we offer the Culturally Adaptive Care Model to demonstrate the importance of uniting the inward and outward aspects of culturally appropriate care. We conclude with an illustration of how the Culturally Adaptive Care Model could be used in a Project ECHO program to support providers seeking to deliver culturally adaptive health care. While we refer to an opioid ECHO program for migrants, the primary

focus of this chapter is on the health acculturation of healthcare professionals as they actively adapt a program to the patients' cultures.

CULTURE AND HEALTH

The United States has a diverse and dynamic population. As of December 12, 2023, the U.S. Census Bureau (n.d.) reports through their website that from 2017 to 2060 the U.S. Black population will increase by 40 percent (from forty-three to sixty million), the Hispanic population will almost double (fifty-seven to ninety-seven million), and the Asian population will also double (eighteen to thirty-six million). The White, Not Hispanic population, however, will decrease by 10 percent (from 197 to 179 million). Further, more than ten million Americans identify as lesbian, gay, bisexual, transgender/transsexual, queer/questioning (Brottman et al. 2020). Demographics such as ethnicity, age, and sexual orientation do not alone define culture, which is a shared system of meanings about beliefs, norms, and practices (Geertz 2017).

Diversity within a society or culture is the richness we experience, with each cultural group contributing their own "learned, shared, and transmitted values, beliefs, norms, and lifeways of specific individuals or groups that guide thinking, decisions, and actions in patterned ways" (Leininger 2006, 10). Cultural diversity influences how we live, what we eat, who we love, and how we worship—it impacts all facets of life, including health. Research has demonstrated again and again a link between culture and health (Campinha-Bacote 2002; Kumagai and Lypson 2009; Napier et al. 2014). And by health, we are not merely referring to the presence or absence of disease or infirmity. We adopt the World Health Organization's understanding of health as listed on their website as a state of complete physical, mental, and social well-being.

Cultural beliefs influence the way people think and feel about personal health and health problems, when and from whom they seek health care, and how they respond to recommendations for lifestyle changes, healthcare interventions, and treatment adherence. Providers' cultural attitudes, beliefs, and values can, in turn, impact the delivery of health care to patients (Tervalon and Murray-Garcia 1998), including how and with whom they communicate about health and health problems. For example, Torres and Rao (2007), comparing how doctors in four countries shared bad news about a patient having cancer, found that while doctors in the United States shared this news with only the patient using direct and explicit communication, doctors in Argentina, Brazil, and India shared bad news first with close family members and then with patients in brief comments over time based on the patients' psychological readiness to receive bad news. Hall (1976) explained that these

differences in communication styles can be attributed to cultures such as the U.S. valuing low-context communication (primary attention to words spoken directly) while cultures like Argentina, Brazil, and India value high-context communication (focus on the words spoken indirectly and circularly, and the contextual meaning of the words spoken).

For more than 40 years, researchers and practitioners have searched for ways to make healthcare delivery more culturally compatible. A dominant perspective has been an outward focus on "cultural competence" that emphasizes the healthcare providers' awareness of others' cultures as a means of being culturally competent communicators (Alizadeh and Chavan 2016; Brottman et al. 2020). A United Kingdom (U.K.) physician, for example, might find herself working with a Syrian immigrant population in her community; as such, she might generally learn about Syrian culture and perspectives on health to engage in culturally compatible healthcare practices more effectively. A second perspective called "cultural humility" takes an inward focus that emphasizes an individual's realization of their own identity and assessment of their own biases. Rather than learning about the cultural and health-related values of her Syrian patient population, this same U.K. physician might reflect on how her own gender, class, Western medical education, and other cultural biases impact patient care.

In the present chapter, we consider these two perspectives and how, together, they can help healthcare providers practice culturally adaptive care in their interactions with patients.

OUTWARD-FOCUSED AND INWARD-FOCUSED PERSPECTIVES

Outward-Focused Cultural Competence

Theoutward focus on cultural competence as understanding others began in the 1960s with the civil rights movements in Western countries to address health disparities resulting from the oppression of Black and Indigenous communities (Jongen et al. 2017). In 2000, the U.S. Health and Human Services' Office of Minority Health released the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care to improve healthcare quality and advance health equity by being respectful and responsive to each person's culture and communication needs. CLAS guidelines are mandated for all healthcare organizations receiving federal funds.

Cultural competence is studied in a variety of health professions, including medicine, nursing, pharmacy, dental, public health, and social work (Brottman et al. 2020). Cultural awareness by a healthcare provider of a patient can take the form of a montage of general to specific information based

on national statistics, social determinants of health, media stereotypes, the immediate community, a patient's family life, and perception of the patient herself. In a systematic review, Alizadeh and Chavan (2016) note that cultural competence studies cross a range of topics, including the impact of physicians' global competence and patient-centeredness on patient satisfaction (Ahmed 2007); the effect of caregivers' linguistic abilities (Chen 2008) and therapists' cultural sensitivity on client satisfaction (Fuertes et al. 2006); and the association between cross-cultural ability and nurses' well-being (Wesolowska et al. 2018).

The physician's outwardfocus emphasizes cultural competence as having or acquiring the appropriate knowledge, attitudes, and skills to work effectively with diverse patients (Betancourt et al. 2003; Purnell 2012). Given that one cannot learn the intricacies of every culture, the cultural skills learned must be at the culture-general and culture-specific levels (Bhawuk 2017). Culture-general frameworks compare and contrast the values, beliefs, and behaviors in any culture. They focus on comparing the conditions in the environment where people live that affect a wide range of health outcomes and risks. Applied to ECHO, a cultural-general perspective we found in our study was the discussion of the social determinants of health across different patient case presentations. Discussions of some patient cases focused on access and quality of care, while other cases focused on economic stability and the community context where care is provided. Culture-specific frameworks provide a deep understanding of one aspect of a particular culture. In our study, we found an example of culture-specific framing where an ECHO hub designed ECHO programs to be culturally compatible with specific indigenous peoples in the Pacific Northwest region of the United States.

While it is broadly accepted that healthcare providers should be culturally competent, there is limited evidence that cultural competence alone impacts health outcomes (Alizadeh and Chavan 2016). Perhaps this is because cultural competence has been defined, applied, and studied in a myriad of ways, resulting in little consistency among findings and interpretations. It is also possible that cultural competence, with its outward focus, often ignores the role of the providers' own cultural values, attitudes, and beliefs in creating culturally competent care. Further, cultural competency has been blamed for tokenism, for assuming that the healthcare provider is from the dominant culture, treating culture as a static phenomenon, and ignoring the role of power in healthcare organizations and the government (Danso 2018).

Inward-Focused "Cultural Humility"

Leaders in health, education, and business have emphasized the importance of self-awareness in making good decisions, communicating effectively with

others, and building relationships. Foronda (2020) adds that in this diverse world, strong cultural self-awareness is key to having efficacious interactions. This inwardapproach focusing on cultural self-awareness was coined "cultural humility" by Tervalon and Murray-Garcia (1998) who defined it as a lifelong process of self-reflection and self-critique whereby the individual learns about another's culture but starts with an examination of their own beliefs and cultural identities.

From the inward focus, providers - consciously or not - are guided by their cultural worldviews, beliefs, and values in delivering care (Bennett 2004). Cultural self-awareness helps providers understand how their beliefs and values impact patient care. Cultural self-identity is shaped by a provider's innate characteristics such as age, gender, ethnicity, sexual orientation, and physical ability, and external characteristics such as income, geographic location, marital status, educational background, and religion (Gardenswartz and Rowe 2010).

Foronda (2020) emphasized that cultural humility is theoretically unique as it is a process of life-long learning, unlike cultural competence, which focuses on a specific interaction with a diverse person. Cultural humility recognizes and attempts to reduce power differences, makes biases explicit, promotes respect for the other, and emphasizes flexibility (Yeager and Bauer-Wu 2013). It emphasizes institutional and individual accountability, lifelong learning and critical reflection, and mitigating power imbalances (Fisher-Borne, Cain, and Martin 2015). Cultural humility can free healthcare professionals from having to possess expert knowledge about a myriad of cultural differences and fosters open communication with patients to achieve shared health and developmental outcomes (Kibakaya and Oyeku 2022).

Fisher-Borne and others refined the definition of cultural humility, emphasizing the importance of three elements: institutional and individual accountability, lifelong learning and critical reflection, and mitigating power imbalances. They stress that research has documented "the positive impact of cultural humility in educational training, acknowledgement of how institutional accountability and the mitigation of systemic power imbalances factor into the core model of cultural humility are missing from the literature" (Fisher-Borne, Cain, and Martin 2015, 173).

Practically, cultural humility is an alternative or complementary basis for achieving culturally adaptive care or quality of care (Danso 2018). Several studies have demonstrated the efficacy of cultural humility, including the improvement of health outcomes for oppressed populations (Kools, Chimwaza, and Macha 2015); enhancement of medical students' patient involvement and attention (Juarez et al. 2006); improvement of child welfare workers' engagement with families (Ortega and Faller 2011); and betterment of physician-patient interactions and health outcomes (Chang, Simon, and

Dong 2012). Further, in their granular analysis of twenty-one studies on the impact of cultural humility in psychotherapy and clinical supervision, Zhang et al. (2022) found that client-perceived therapist cultural humility was linked to positive treatment outcomes (Kivlighan et al. 2019; Owen et al. 2014, Owen et al. 2016), lower frequency and lower impact of racial microaggressions (Hook et al. 2016), and lower color-blind racial attitudes (Stewart 2019). Foronda et al. (2016) add that enacting cultural humility includes being other-centered, having a flexible mindset, and using supportive verbal and nonverbal communicative behaviors. Cultural humility is an important and useful orientation to others that does not necessarily require healthcare providers to have expert knowledge about other cultures; rather, reflection and increased awareness of one's own culture are primary.

There is a presumption that cultural humility leads to positive health outcomes and an appreciation of diversity, equity, and inclusion. Research over several decades, however, indicates that cultural humility has limitations like cultural competence—lack of conceptual clarity, challenges in measurement, and missing evidence of positive healthcare outcomes (Alsharif 2012; Foronda et al. 2016; Yeager and Bauer-Wu 2013). Danso (2018) argues that cultural humility has been unsuccessful in demonstrating a positive impact on patient health outcomes.

THE CULTURALLY ADAPTIVE CARE MODEL

Research aboutoutward-focused cultural awareness and inward-focused cultural humility has advanced our understanding of how healthcare providers can work effectively with diverse patients. Alone, each approach is incomplete. We posit that it is insufficient to focus either on the healthcare providers' knowledge of diverse patients' cultures (cultural competence) or the providers' self-awareness of their own cultural attitudes and biases (cultural humility). Each approach ignores the totality of what a provider and the patient bring to their interaction. Combining the outward focus and inward focus creates an additive positive effect.

The Culturally Adaptive Care Model combines outward-focused cultural competence with inward-focused cultural humility (figure 7.1). When these two perspectives are joined, providers gain greater cultural self-awareness (Roysircar 2004; Tervalon and Murray-Garcia 1998; Winkelman 2005), cultural self-identity (Gardenswartz and Rowe 2010; Rao 2023), and a deeper understanding of the patient's identity, beliefs, values, and the patient's preferred communication styles (Goettsch 2014; Gudykunst et al. 1996; Hall 1976; Keller 2014). Ultimately, the providers bring these perspectives to communicative interactions with patients.

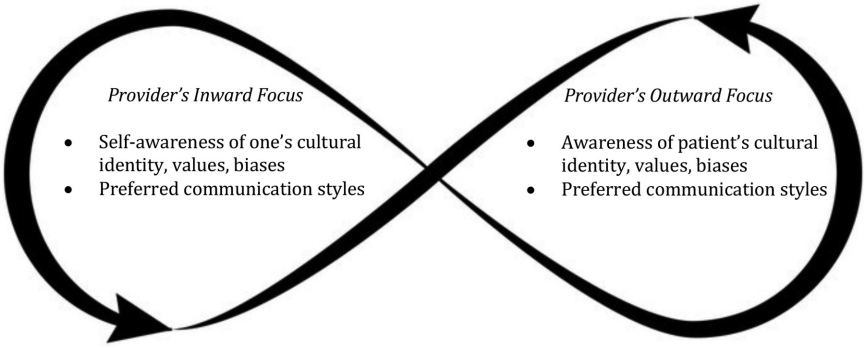

Figure 7.1 Culturally Adaptive Care Model. *Source*: Figure by authors.

The Culturally Adaptive Care Model does more than bring the inward and outward focus together. It indicates that there is a flow and interaction between the two foci. As a healthcare provider learns more about a patient's cultural identity, this knowledge is likely to influence that provider's values and preferences. When providers better understand their own values, it influences their awareness of the patient's cultural identity.

In addition, the Culturally Adaptive Care Model emphasizes the importance of communication styles, especially as applied to a patient-provider communicative interaction. The theoretical framework underpinning communication styles comes from Hall's (1976) model of low-context and high-context cultures. Hall explained that

> A high context communication or message is one in which most of the information is already in the person, while very little is in the coded, explicit, transmitted part of the message. While a low context communication is just the opposite; the mass of the information is vested in the explicit code. (Hall 1976, 111)

Studies show that communication styles vary by cultural groups (Gudykunst 1998; Hall 1976; Hofstede 2001). It is important for the provider to know their own and the patient's preferred communication styles. Communication styles for different cultural groups exist on a continuum and not everyone from a specific cultural group uses the same communication style.

Culture also impacts the nonverbal aspects of communication styles. The preferred volume, tone, and speech rate (number of words per minute) vary across cultures. For example, loud and expressive speech at a higher speech rate is common in Latino, Arab, and African American cultures, while a softer and less expressive speech at a slower speech rate is common in East Asian cultures (Think Cultural Health, n.d.). Further, culture also impacts the extent and type of eye contact, use of pauses and silence, touch, and proximity in

conversations. Street, Gordon, and Haidet (2007) found that clinicians were more engaged and gave more information to patients with higher education (better spoken) even when the patient did not seek this information. Holmes (2012) noted that Mexican migrant workers were likely to get poorer care because of what they wore and how they smelled.

Several studies demonstrate that miscommunication, often due to different communication styles between the healthcare provider and patient, has a negative impact on health outcomes and patient safety (Crawford, Candlin, and Roger 2017; Hamilton and Woodward-Kron 2010), delayed treatment, misdiagnosis, medication errors, and death (Australian Commission on Safety and Quality in Health Care 2012; Interprofessional Education Collaborative 2011).

APPLYING THE CULTURALLY ADAPTIVE CARE MODEL TO PROJECT ECHO

Earlier, we indicated that during interviews, health specialists and ECHO administrators asked us, "What advice do you have for us? What framework or tools are out there that we can use to design ECHO programs that lead to more culturally competent healthcare?" Below, we present a simulated Project ECHO scenario based on a composite of the ECHO programs in our study to illustrate how Project ECHO teams and other healthcare training interventions can use the Culturally Adaptive Care Model as a framework to support healthcare providers in delivering culturally adaptive care.

An ECHO hub at a large Midwest academic medical center has been funded by the State Department of Health to develop an Opioid Use ECHO program. The ECHO program is being led by two board-certified addiction and pain medicine physicians who initially approached the State to fund a three-month weekly ECHO program for rural providers who encounter patients using opioids. They are joined by an ECHO administrator who facilitates the initiation of ECHO programs. These three individuals constitute an ECHO team. The ECHO team holds a planning meeting to discuss opioid use in rural counties of the state. One physician commented that part of the rural population being underserved were migrant workers. This physician references a recent study that found migrant workers were often reluctant to seek medical care as they feared contact with law enforcement while traveling to or from the clinic. This same study recommended that health clinics could place a greater emphasis on patient-centered care that aligns culturally and linguistically with their clients' needs.

After discussing this research and the lived experiences of the two physicians, the ECHO team realizes that they need to expand their membership and

create an ECHO panel of experts. They talk to their colleagues and identify a social worker and psychologists who have both been working with opioid users, and another physician who works with migrant populations. They contact the university outreach office and identify a migrant community organizer who has expressed an interest in doing more to improve healthcare access for migrant workers in the state. The ECHO team convenes these individuals; they explain the ECHO model, identify the problem they are addressing, and invite them to join this ECHO's panel of experts. By expanding the panel to include experts with complementary knowledge about the population, the ECHO program is increasing its outward focus and improving its efficacy. A first step, then, is to create an inclusive set of experts who can complement each other's knowledge of a condition, its treatment, and the population's cultural characteristics that impact care and treatment.

With an ECHO panel of experts assembled, the ECHO administrator explained that they would be using the Culturally Adaptive Care Model throughout the twelve ECHO program sessions. The purpose of using the model is to support the ECHO participants (spokes) as they provide care to migrant workers and their families, who are often viewed with stigma by residents. A next step, then, is to commit to integrating the model throughout all ECHO program sessions. To design their curriculum in a culturally adaptive manner, the ECHO panel members gather data to learn more about themselves (figure 7.1; Providers' Inward Focus) and the patient population served by the ECHO program (figure 7.1; Providers' Outward Focus).

To strengthen the inward focus, ECHO panel members each commit to reflecting on their own cultural identities, values, and biases by completing a self-assessment tool, the I-Map (Rao 2023), which is an aid to learning about one's own cultural self-identity. Table 7.1 provides questions (Providers' Inward Focus column) for each panel member to consider and record their answers. In their second planning meeting, participants set aside time to discuss what they have learned about the panels and each member's cultural identity and how it might impact their presentations. They have now each gained a deeper understanding of self and the collective.

To better understand the patients that participants care for, with an outward focus, the ECHO team uses data from the Centers for Disease Control and Prevention (CDC), U.S. Census, and other public health resources to learn about migrant populations and opioid patient populations in their region by age, gender, ethnicity, class, and other demographic dimensions. To glean more about the relationship between the opioid patients' culture and their health beliefs, the ECHO panel members read the article about migrant workers and access to health care that the lead ECHO physicians had discussed earlier. Migrant community organizers are also invited by the expert panel to share their expertise in working with this community, including values and/

Table 7.1 Providers' Question Guide to Learn About Self and Patients

Providers' Inward Focus Self-Awareness	*Provider's Outward Focus Awareness of Patient*
• How does my cultural identity broadly shape my healthcare beliefs and values? • Which aspects of my cultural identity are salient for interactions with a patient from a specific culture? • What are my first reactions to patients who look or don't look like me? • How does my cultural identity help or hinder my interactions with a patient? What are my blind spots and biases? • Do I vary my approach and communication based on the patients' culture? If yes, how? • What do I project onto others? Which parts are received well or not received well, by whom? • What have I learned by providing care to clients who don't look like me?	• How do my patient's cultural identities broadly shape their healthcare beliefs and values? • Which aspects of the patient's identity seem to be most salient during healthcare interactions? • What are the initial reactions to me from patients who look or do not look like me? • What are the patients' preferred communication styles? Do I notice my culturally diverse patients struggling to communicate with me during healthcare interactions?

Source: By authors.

or stories of health experiences. These multiple sources of information are brought together to identify gaps in care, including cultural dimensions of care. The panel gathers for an initial ECHO facilitator training session during which they invite a faculty member who studies health communication to provide an overview of the role that communication can play in acculturation. The panel members answer questions in table 7.1, second column, providers' outward focus. By using these primary and secondary data, the ECHO panel has used an acculturation process to deepen their understanding of the ECHO team and their patient population's culture and health beliefs.

Combining the results from the inward and outward-focused data, the ECHO team is now ready to develop an opioid use curriculum for the program's twelve sessions. Prior to the first ECHO session, the team invites each spoke participant to complete the I-Map and answer questions from table 7.1 to learn about themselves and the patient population. Table 7.2 offers one way to apply the Culturally Adaptive Care Model across the twelve sessions.

Participants are recruited through multiple outlets. The team requests information from the state medical association to identify physicians in rural counties, many of which have migrant worker populations, and invites them to participate. In addition, the panel members reach out to their social networks, information is shared with local public health offices, and an announcement is placed in a monthly newsletter. The first Opioid Use ECHO session

Table 7.2 Opioid Use ECHO Program Session Guide

Session #	*Topic*	*Culturally Adaptive Care Model Questions/Prompts*
1	Introductions – ECHO team and participants	Instruction: You will work in pairs and will be introducing your partner. Some questions to explore: • Where were you born? Tell me about your family growing up. • Using the I-Map, share the two most important cultural identities and the two least cultural identities. What do you make of the similarities and differences? • Share one fun fact about yourself.
2	Case 1 from Hub presenter	Clinical content Culture component: Using answers from column 2, table 7.1, • What are the key aspects of the patients' cultural identity? • How does this identity (or identities) relate to opioid use? • What are the patients' beliefs about opioid use? How does the patients' cultural identity and beliefs influence our understanding of the case?
3	Case 2 from participant	Clinical content Culture component: • How does the patients' cultural identity and beliefs influence our understanding of the case? • Based on answers to the first question, how can we take better care of patients?
4	Case 3 from participant	Same as session #2
5	Case 4 from participant	Clinical content Culture component: • Culture and health expert presentation
6	Case 5 from participant	Same as session #2
7	Case 6 from participant	Clinical content Culture component: Questions for ECHO team members and participants: • What we learned from the first five sessions about our own cultural identity, our strengths in taking care of patients, and our biases? • What will we change going forward?
8	Case 7 from participant who brings a volunteer patient	Clinical content Culture component: • Request patient to present their case and provide feedback on their care. • Questions from the team and participants: How can we take better care of you?
9 - 11	Case 8–11 from participant	Same as Session #2

(*Continued*)

Table 7.2 (Continued)

Session #	*Topic*	*Culturally Adaptive Care Model Questions/Prompts*
12	Debrief and conclusion	Clinical content • Culture component: ParticipantsWhat stood out about culture from the 11 sessions? • What are two things you will do differently in patient care based on the 11 sessions? Team members: • What stood out about culture from the 11 sessions? • What are two things we will do differently in designing the next opioid program?

Source: By authors.

consists of introductions. During this session, the ECHO administrator shares information about the populations of opioid users in their area and briefly discusses general cultural characteristics. Next, the participants and panel members get to know each other using the I-Map. The ECHO administrator also shares a template that participants will use when presenting a patient case during an ECHO session. Consistent with the questions in table 7.1, the template includes questions about the social determinants of health that may impact the patient's condition and care. The template also includes a question about what the provider is bringing into the patient interaction as well as what the patient may be bringing. The case template prompts the ECHO participant to think about their own cultural competence and cultural humility.

As participants present cases during each ECHO session, the ECHO hub team prompts a discussion about cultural competence and cultural humility. Apart from the questions in table 7.2, a hub team member might ask the participants, "Did this patient look like you or not? How did that influence your initial assessment or interaction?" Or they could turn the question around and ask, "Did this patient look like you or not? How did that influence their assessment of you?" The team also asks participants questions about communicative interactions, including how the patient responded to questions and how the participant shaped their communication to fit what they knew about the patient, including how the patient preferred to communicate.

To offer depth to participant learning, one session includes a presentation on culture and health from an expert focusing especially on communication styles. A second session features a patient volunteer who shares the pluses and minuses of their care. The ECHO panel and participants learn how the patient's cultural identity impacted their lived experiences and their expectations in patient care.

The ECHO administrator distributes an evaluation at the end of each session and at the end of the program. The evaluation includes questions about the provider's interaction with patients from different cultures and how the provider has adapted their care over time. Asking questions provides important feedback to the ECHO team and serves as a reminder for the participants that providing culturally adaptive care is important.

Finally, the ECHO team meets briefly at the end of each session to debrief. During the debrief, the team identifies opportunities and ways to create more focus on developing culturally adaptive care. They also reflect on their own practices—Did they use stigmatizing language? Did they show empathy? They make changes to ensure that whenever possible, and where it makes the most sense, they are incorporating the Culturally Adaptive Care Model in their ECHO program.

FUTURE STEPS

The Culturally Adaptive Care Model asks healthcare providers to look inward and outward—to focus back and forth on cultural humility and cultural competence, based on a patient's cultural background. It acknowledges that as healthcare providers gain cultural humility, their cultural competence improves, which in turn enhances cultural humility. This acculturation process is one of iterative, recursive learning about the ECHO team's and the patients' cultures. The model comes to life when it is used by providers as they communicatively interact with patients. Prior to meeting with the patient, the providers can pause and consider the values, beliefs, and biases they are bringing into the conversation even as they consider what they know about this patient's culture—generally and specifically.

The Cultural Adaptive Care Model is a new and developing model that will be refined with testing and application. The model's value and application go beyond provider-patient interactions to mentoring and learning by and among healthcare providers so that they can be better at helping disadvantaged populations such as migrants, who are often reluctant to seek medical care. It can be effectively used at an individual and group level (as shown with Project ECHO) in health care, education, profit and nonprofit businesses, and government. With a continued and enhanced focus on diversity, equity, and inclusion issues in education (Cumming, Miller, and Leshchinskaya 2023) and business (Ferraro, Hemsley, and Sands 2023), the Cultural Adaptive Care Model can help universities and healthcare institutions create inclusive curriculum and global businesses shape efficacious virtual teams.

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