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Comparative Effectiveness Review Disposition of Comments Report

Research Review Title: *Improving Cultural Competence To Reduce Health Disparities*

Draft review available for public comment from June 22, 2015 to July 20, 2015.

Research Review Citation: Butler M, McCreedy E, Schwer N, Burgess D, Call K, Przedworski J, Rosser S, Larson S, Allen M, Fu S, Kane RL. Improving Cultural Competence To Reduce Health Disparities. Comparative Effectiveness Review No. 170. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2012-00016-I.) AHRQ Publication No. 16-EHC006-EF. Rockville, MD: Agency for Healthcare Research and Quality; March 2016. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Comments to Research Review

The Effective Health Care (EHC) Program encourages the public to participate in the development of its research projects. Each research review is posted to the EHC Program Web site in draft form for public comment for a 4-week period. Comments can be submitted via the EHC Program Web site, mail or E-mail. At the conclusion of the public comment period, authors use the commentators' submissions and comments to revise the draft comparative effectiveness research review.

Comments on draft reviews and the authors' responses to the comments are posted for public viewing on the EHC Program Web site approximately 3 months after the final research review is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator, if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

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Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 1	Abstract	Review methods. TYPO NOTED - Eligible studies included randomized controlled trials (RCTs), prospective cohort studies, and other observational studies with comparators that evaluated cultural competence interventions aimed AT reducing health disparities in the formal healthcare system for three priority population groups:…	Thank you, we added AT to this sentence.
Peer Reviewer 1	Abstract	The following UNCLEAR SENTENCE should be modified: Since evidence was sparse, qualitative analysis and description of research needs is provided.	Thank you, we replaced the sentence with "Given the sparse and patchy literature that precluded pooling, a qualitative analysis is provided."
Peer Reviewer 1	Abstract	Results. …UNCLEAR SENTENCE - Further, one such intervention reported an unintended consequence, possibly the result of reinforcing stereotypes or increasing stigma.	Thank you, we reworded this sentence: "One included study reported a potential harm from provider training, an increase in negative attitudes or stigma resulting from intervention."
Peer Reviewer 1	Abstract	Another UNCLEAR SENTENCE- These programs tended to weigh heavily on common identity and cultural attributions and, in some cases, were less effective in subpopulations that were less tied to the community. I am not sure what this means.	Thank you, we provided additional information : "One potential limitation of these types of interventions is that they rely on strong identification with a common culture. The population groups highlighted in this review are large and diverse. Creating an intervention for "African Americans" or "women who have sex with women" may be differentially effective for specific subpopulations."
Peer Reviewer 1	Abstract	The paragraph that begins "Methodological problems are pervasive…" should be the conclusion. The actual Conclusion ends with a sentence that is vague and UNCLEAR-	Thank you, we moved this sentence to the beginning of the conclusion section and deleted the confusing sentence.
Peer Reviewer 1	Abstract	"Significant between and within group variation in population visibility also affects interventions to reduce disparities." I don't know what you are saying.	Thank you, we removed this sentence and provided additional information: "There are many gaps in the literature; many large subpopulations are not represented."
TEP 1	Abstract	Line 21: ?Missing word – "interventions aimed at reducing…"	Thank you, we added AT to this sentence.

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Commentator & Affiliation	Section	Comment	Response
Leslie Hausmann	Abstract	Not provider-level?	Thank you. Provider level interventions were included. This sentence now reads: "To examine existing system-, clinic-, provider-, and individual-level interventions…"
Leslie Hausmann	Abstract	delete is	Thank you, the sentence with the extra word has been removed.
Leslie Hausmann	Abstract	not sure what is meant by "patient-held medical records"	Thank you, we have provided additional information. This sentence now reads: "The most prominent example of such an intervention was a document, similar to a medical record, that patients carried to their appointments to prompt providers to evaluate areas of known disparity for a specific population."
Leslie Hausmann	Abstract	"not sure what is meant by this sentence. Is it the population visibility overall that varies, or is it within-population visibility (e.g., some minority members pass for majority members)?"	Thank you, we removed this sentence and added: "There are many gaps in the literature; many large subpopulations are not represented."
Peer Reviewer 1	Introduction	Page 10: Culturally competent care is seen as foundational for reducing disparities through culturally sensitive and unbiased care. The final phrase doesn't seem necessary –DON'T YOU MEAN Culturally competent care is seen as foundational for reducing disparities. ?	Thank you, we shortened this sentence as suggested.
Peer Reviewer 1	Introduction	Page 11: The following sentence under the "Includable interventions that lie…." Is not clear: Interventions that take place at the system level, engineering a system that prompts physicians to pay attention to areas of known KNOW WHAT? , such as equitable receipt of preventive care or chronic disease management.	Thank you, we added the word "disparity" to this sentence

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Peer Reviewer 1	Introduction	For example, people with disabilities commonly experience an identifiable set of health conditions secondary to the disability such as urinary tract infections, asthma, obesity, hypertension, and pressure ulcers.4 THE EXAMPLE DOES NOT FOLLOW THE LEAD IN.	Thank you, we removed the confusing language and added a clearer example of the rule. The full sentence now reads: "Interventions that take place at the system level, engineering a system that prompts physicians to pay attention to areas of known disparity, such as passport interventions prompting equitable receipt of preventive care or chronic disease management for people with a disability."
Peer Reviewer 1	Introduction	The analytic framework in Figure 2 is missing PROVIDER KNOWLEDGE which is just as important as attitudes in changing behaviors. I do not know why it is left out of Provider intermediate outcomes.	Thank you, we revised provider intermediate outcomes in Figure 2 and Table 1. to include provider knowledge.
Peer Reviewer 1	Introduction	In addition, The final health outcomes need to be reduced disparities between target group and general population, and improved health outcomes. These are not what is stated in the FINAL HEALTH OUTCOMES box.	Thank you, we added the following introductory sentence to the Final Health Outcomes box: "Reduced disparities between target group and general population in terms of…" to match the entries in Table 1.
Peer Reviewer 1	Introduction	Figure 3. Study selection… makes sense except of the section “Translation or culturally tailored media” In the paragraph below the Figure there is examples of brochures and videos used to describe this phrase but it isn’t clear what this means. Are you saying you downgraded manuscripts that tested the effectiveness of brochures and videos that were intended to change knowledge, attitudes or behaviors? Why?	Thank you, yes, we did exclude manuscripts that only tested the effect of tailoring a brochure or video to one of the target populations. This exclusion criteria was most important for the racial/ethnic minority populations because there were a large number of interventions that only changed the primary language or images in an existing brochure or video.

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Commentator & Affiliation	Section	Comment	Response
TEP 1	Introduction	The concept of “diversity competence” should be further defined and appropriate citations included. For example, see The Four Skills of Cultural Diversity Competence by Mikel Hogan. http://www.amazon.com/Cultural-Diversity-CompetencePractice-Populations/dp/0840028628	Thank you for the comment. We intended with the term “diversity competence” to reach beyond the concept of culture. Since this report includes people with disabilities, but not all people with disabilities would embrace or endorse the idea of culture as a group identifier, the term “culture” may not be considered appropriate by all readers. However, many people with disabilities do experience disparities in health care. A similar argument may be made for populations within the LGTB communities who may or may not endorse the term “culture.”
TEP 1	Introduction	?Missing word – “to pay attention to area of known [???] , such as …”	Thank you, we added the word "disparity" to this sentence
TEP 1	Introduction	The authors list patient health behaviors … and use of preventive services, and other access to care measures as being Final health or patient-centered health outcomes under KQ3 but for KQ2 and KQ4, these are listed as being patient intermediate outcomes. Shouldn’t there be consistency across the various KQs (i.e., these should be intermediate outcomes?)	Thank you. The reviewer points up the challenge of classifying what are intermediate and final outcomes when the different populations of interest experience different disparities and have different priorities, values, and goals of treatment. This view was confirmed with the multiple discussions with key informants while establishing the outcomes for the PICOTS (Table 1). After several rounds of reviewing possible generic or multiple specific analytic frameworks, we decided to use a simplified generic analytic framework and let the PICOTS in Table 1 list the specific outcomes of interest for each population group.
Peer Reviewer 2	Introduction	Should read ‘racial/ethnic minority children and adults’.	Thank you, we made this correction where needed throughout the report.

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Commentator & Affiliation	Section	Comment	Response
TEP 2	Introduction	In Chapter 1, under Background, I recommend using stronger language throughout about why this work is important and needed	Thank you for the comment. We agree with the reviewer on the importance of the topic. We have chosen to leave the language general as originally written. The report emphasizes the importance of the work in multiple sections.
TEP 2	Introduction	Also in this section you have two sentences that list the 3 populations of interest. You might consider rewording the second one in a different format in a way that eliminates the need to list each of the populations again.	Thank you, the referenced paragraph was duplicative and has been removed.
TEP 2	Introduction	I had a difficult time understanding Figure 2. I recommend clarifying what is supposed to inform what. Some of the boxes are not linked. Some text is not in boxes. And, the meaning of the different size and shape of the lines is unclear.	Thank you for the comment. We used an analytic framework template recommended in AHRQ EPC guidance. A brief note is provided under the framework. Interested readers may review the AHRQ guidance in more detail, available at http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&mp=1&productID=318
TEP 2	Introduction	Similarly, Figure 3 was difficult to understand. I don't believe that someone could understand this figure without the accompanying text.	Thank, we revised Figure 3. to allow the figure to stand alone without the accompanying text.
TEP 2	Introduction	This sentence is unclear; it seems to be incomplete. "Therefore, we summarized the results into evidence tables and conducted a qualitative synthesis, grouping synthesis results using emergent patterns from identified interventions, and evaluating the challenges of the literature the present barriers to forming inferences from study results."	Thank you, we revised this sentence. It now reads: "Therefore, results are summarized into evidence tables and qualitatively synthesized by common characteristics of interventions and outcome measures. Barriers to forming inferences from study results are also presented."

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Commentator & Affiliation	Section	Comment	Response
TEP 3	Introduction	The Department of Health and Human Services uses the term minority to refer to specific populations. As examples, please note definitions by NIH/NIMHD and the HHS Office of Minority Health. As such, it is important for this report which is being produced on behalf of HHS to reflect this, and only utilize the term minority when referring to racial and ethnic population. The term GSM should NOT be used and replaced with the term LGBT throughout the document. The Office of Minority Health is also referenced in this document, again highlighting the need for this change. In addition there is terminology that suggests persons with disabilities could be considered a minority group. That needs to be changed throughout. An example of this can be found on page 66 line 27 and 28 ("Many people with disabilities may be covered by Medicaid and face the same limitations to access to care or restrictions in options faced by other minorities") Please note a population that experiences a disparity is not a minority.	Thank you, to be consistent with the Department of Health and Human Services, we used LGBT instead of GSM throughout the report. We have changed the sentenced reference as follows: "Many people with disabilities may be covered by Medicaid and face the same limitations to access to care or restrictions in options faced by racial/ethnic minorities."
TEP 3	Introduction	Cultural Competence Section needs to include a description of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)	Thank you, the CLAS Standards are referenced in Chapter 1, paragraph 1.
Beth Kingdon	Introduction	English as a second language is referenced. For many people who come to the US English is the not the second language that they learn but may be their third or fourth language. We cant perpetuate the concept that just because someone isnt fluent in English that they only speak one language.	Thank you, we replaced "second language" with "not his/her first language."
Leslie Hausmann	Introduction	delete all	Thank you, we have deleted this word.
Leslie Hausmann	Introduction	this isn't the proper use of semicolons	Thank you, we have changed the semicolons in this sentence to commas. The sentence now reads: "The standards cover governance, leadership, workforce, communication and language assistance, organizational engagement, continuous improvement, and accountability."
Leslie Hausmann	Introduction	insert minority	Thank you, we inserted the word minority between ethnic and population in this sentence

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Commentator & Affiliation	Section	Comment	Response
Leslie Hausmann	Introduction	remove s on differs	Thank you, we have made this change.
Leslie Hausmann	Introduction	add s to young adult	Thank you, we have made this change.
Leslie Hausmann	Introduction	what is meant by final health outcomes	Thank you, final health outcomes or patient-centered health outcomes refer to downstream, or long-term effects of an intervention. These outcomes are in contrast to intermediate outcomes which are generally markers of the changing process.
Leslie Hausmann	Introduction	add to "service to people with disablities"	Thank you, we changed this sentence.
Leslie Hausmann	Introduction	add and "clinical decision making and communication"	Thank you, we made this correction
Leslie Hausmann	Introduction	add about "beliefs/cognitions about the priority population"	Thank you, we made this correction
Leslie Hausmann	Introduction	incorrect population [pg 4]	Thank you, we made this correction.
Leslie Hausmann	Introduction	Overall I find the different line styles to be distracting. I suggest making the line styles more uniform. If the different styles (thick vs. thin, straight vs. curvy, solid vs. dashed) are supposed to convey different meanings, that message was lost on me.	Thank you for the comment. We used an analytic framework template recommended in AHRQ EPC guidance. We prefer not to distract readers from the main topic of the report by giving detailed descriptions of the functions of the different shapes and arrows. Interested readers may review the AHRQ guidance available at http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&mp=1&productID=318

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Metti Duressa, on behalf of Ivonne Cameron, CEO of Hepatitis Foundation International	Introduction	Greetings I am submitting comments on behalf of Ivonne Cameron CEO of Hepatitis Foundation International.The HFI is a 501 c 3 nonprofit organization entering its third decade working to eradicate chronic hepatitis globally. HFI is dedicated to increasing and promoting health and wellness as well as reducing the incidence of preventable liver related chronic diseases and lifestyles that negatively impact the liver for the more than 5 million constituents we represent nationwide. HFI welcomes the opportunity to submit comments to AHRQ to address cultural competency and health disparities in health environment.	Thank you for your comment
Peer Reviewer 1	Disability	Overall, I would suggest using the phrase “people with disability” instead of the plural “disabilities”. Most people have only one disability and we do not say “people with cancers”.	Thank you for your comment. We continued to use "people with disabilities” in the report. We believe this construction is widely accepted. When referring to a group a people, the disabilities present may be of many different forms. Similarly, there are many people with disabilities who do have more than one form of disability. However, overall we revised the report to group plural with the plural form of disabilities and individuals with the individual for of disability.
Peer Reviewer 1	Disability	Again, I would suggest using the singular for of “disability” The lead in paragraph should say “…13 percent of children and youth ages 3 to 21 have disabilities a disability…”	Thank you, we changed this sentence from "have disabilities" to "have a disability"
Peer Reviewer 1	Disability	The first paragraph on Scope of the Review doesn’t make an important point that is relevant to this chapter. There needs to be some mention of DIFFERENCES as compared to Disparities. Sometimes people with a specific disability manifest health conditions in a way that is not typical. Providers need to understand these differences and take appropriate action. This is a content area that falls under the domain of KNOWLEDGE and is amenable to evaluation.	Thank you for your comment. We excluded interventions that only educated providers on clinical protocols for treating persons with a disability.

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Peer Reviewer 1	Disability	Not clear about the sentence "Interventions aimed at improving physician or patient knowledge of existing treatment guidelines for conditions experienced by people with disability are not included unless they also targeted physician perceptions and/or patient access to care." Are you saying you did not include articles that describe interventions to teach physicians about medical care accommodations for people with disability? It seems like those articles should be included.	Thank you for your comment. We excluded interventions that only educated providers on clinical protocols for treating persons with a disability.
Peer Reviewer 1	Disability	Figure 4- The exclusion criteria for the 139 full text reviews should be made more specific since this is a critical step. The 35 papers that were excluded for design need to have elaboration- no comparison group? What else?	Thank you, we have clarified the rationale for excluding articles based on their methodology or design and provided some examples. Appendix C, the location of excluded articles and reasons for exclusion, is noted earlier now in the Methods section.
Peer Reviewer 1	Disability	Table 4 and Page 30 Table7. These are important features of the studies that need to be specified more clearly. In terms of "Reported General Findings" in both tables we need to know the magnitude of the effect and the type of statistic used to assess it. What statistic was used? What was the Odds Ratio or Risk Ratio? What was the p-value or confidence interval? Did they control for confounders?	Thank you, we made a decision not to report magnitude of statistics, but only direction and significance. The rationale for this decision is based on our determining that current studies are provide an insufficient level of evidence to answer the research questions, in large part due to the high risk of bias of the included studies, small sample sizes, and lack of ability to pool studies.
Peer Reviewer 1	Disability	I think it would be best to list the shortcomings of the identified studies, using a systematic format similar to the tables that describe the findings. The categories could be PROBLEMS with: design, sample size, randomization, questionnaires or measures of attitudes, knowledge or behaviors, length of follow-up, and statistics. Enumerating the problems is essential to developing better studies in the future.	Thank you, a summary of the shortcomings of the studies can be found in the Risk of Bias tables in Appendix D .
Peer Reviewer 2	Disability	How do we know traction was gained in 1990?	Thank you, the language referencing gaining traction has been removed.

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Peer Reviewer 2	Disability	This sentence is confusing? Is it one study on mental illness, one on arthritis and one on multiple sclerosis? If so, rephrase 'the three studies' at the start of the sentence.	Thank you, we divided the confusing sentence into two sentences. It now reads: "The studies aimed at reducing barriers to accessing care were delivered by psychologists, occupational therapists, and masters prepared counselors. One of the four studies targeted people with mental illness, one focused on people with arthritis, and two focused on people with multiple sclerosis.
Peer Reviewer 2	Disability	word missing after may be?	Thank you, this sentence was removed with the revision of the discussion section.
TEP 1	Disability	?Missing words – "should involve …[???]"	Thank you, we have corrected this sentence. It now reads: "The work of developing definitions for cultural competence as well as effective solutions for improving providers' knowledge and training in the health needs of people with disabilities should involve people with disabilities."
TEP 1	Disability	The authors should consider providing some appropriate citations relating to the concept of "disability culture" or "disability cultures."	Thank you, we expanded the introduction section on cultural competence, adding a reference and a definition for "disability culture."
TEP 2	Disability	In Chapter 2, under Health Disparities, it is worth noting that the ICF model is relatively new and the health care setting has not yet fully embraced it. As a large component of this, many health care and public health providers have not embraced the idea that disability and poor health do not have to be synonymous. (You begin to address this in Chapter 5, but it is important to mention it here as well)	Thank you, we believe presenting the chapter through the ICF, as a well-respected construction of disability, is appropriate. We feel Chapter 5 is the better place to address the issue of disability not being equated to poor health.
TEP 2	Disability	I also recommend including citations for the work described in the first and second paragraphs You may also want to mention that Healthy People 2020 include disability as a separate population, and includes objectives that relate to cultural competence, and that the Surgeon General has highlighted the importance of addressing these concerns.	Thank you for the additional references. We have provided these references as a supplement to this table of review comments and responses.

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TEP 2	Disability	This type of work is often not undertaken because health care providers are frequently concerned about cost of making the change in physical structures (despite tax breaks) and they are also concerned about liability under the ADA.	Thank you for the comment. It is outside the scope of this review to determine why providers do or do not make changes to the physical structure of the clinic.
TEP 2	Disability	This sentence is unclear; it seems to be incomplete [pg 33]	Thank you, we have corrected this sentence. It now reads: "The work of developing definitions for cultural competence as well as effective solutions for improving providers' knowledge and training in the health needs of people with disabilities should involve people with disabilities."
TEP 2	Disability	It is worth noting that the funds available for this type of research are very limited, especially as it relates to people with disabilities. This stems, in part, from the fact that most funders do not yet endorse the idea of people with disabilities as a population that experiences health disparities, and a population that can be healthy.	Thank you for the comment.
TEP 2	Disability	effect should be affect	Thank you, we have made this change.
TEP 2	Disability	Additional References	Thank you for the additional references. We have provided the relevant references the reviewer has supplied as a supplement to this table of review comments and responses.
Beth Kingdon	Disability	The statement ...no clear lines of demarcation can be easily drawn to separate patient-centered care health literacy or other quality improvements from cultural competence. There shouldn't be a line between cultural competence cultural competence is a necessary component of patient-centered care.	Thank you for your comment. This is one of the more challenging parts of this review. We argue, as have others, that these concepts, while overlapping, are distinct. In this review, we were tasked to evaluate cultural competence interventions, not patient-centered interventions.
Leslie Hausmann	Disability	insert : after of	Thank you, we made this correction
Leslie Hausmann	Disability	change "at" to "based on"	Thank you, we made this correction

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Commentator & Affiliation	Section	Comment	Response
Leslie Hausmann	Disability	change "stated using" to "used"	Thank you, we made this correction
Leslie Hausmann	Disability	insert space between "standard" and "mental"	Thank you, we made this correction
Leslie Hausmann	Disability	I was wondering when the findings of the studies would be summarized. I believe this is the first time any results were mentioned, and the statement is very uninformative. Consider orienting the reader to the arrow symbols used in the table to learn about the patterns of findings across the various studies rather than to just refer readers to Table 6 at the start of the paragraph. Also consider mentioning in the text that Table 6 is organized by outcome AND indicates whether the interventions showed signs of success.	Thank you for the comment. We added a paragraph summarizing the patterns of findings from Table 6.
Leslie Hausmann	Disability	It would be nice if there was some consistency with how findings are summarized across the various tables. I understand that you can provide more in-depth detail about studies when there are fewer to display in a single table, but could you also incorporate some of the structure or use of arrows from the previous table into this one?	Thank you for the comment. It was difficult to summarize the outcomes from the included physician-patient interaction interventions (Table 7) in the same manner as the educational interventions (Table 6) because there were not as many common outcomes.
Leslie Hausmann	Disability	what does "patient-carried records with clinical prompts " mean, exactly	Thank you for the comment. We added several sentences further clarifying the intervention.
Leslie Hausmann	Disability	this is a lot more detail than what was provided on studies discussed in other sections. Consider using comparable levels of detail across sections for consistency.	Thank you, we added more detail to this section to balance the other sections.
Leslie Hausmann	Disability	remove "nor"	Thank you, we reworded this sentence. It now reads: "An intent to treat analysis found significant effects of the intervention on all three subscales of the fatigue impact severity measure and the role physical subscale of the SF-36; fatigue severity, self-efficacy, and the other seven domains of the SF-36 did not differ significantly."

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Leslie Hausmann	Disability	I was glad to see this paragraph. In addition to looking at the intersection of race ethnicity and disability it is time to move beyond studying vulnerable populations in isolation in general given that several intersecting characteristics can put people at risk for poor health and health outcomes. I applaud the position articulated in this and subsequent chapters that the field of cultural competence needs to move beyond seeing patients or groups of patients as defined by single dimensions. Rather than focusing on people as members of a single group e.g. gender sexual minority OR racial minority OR person with a disability etc. the field needs to recognize and embrace the complexity of social identity and find ways to ensure that the health and health care needs of all individuals are being met. Encouraging a reframing of cultural competence as diversity competence is a step in the right direction.	Thank you for the comment.
Leslie Hausmann	Disability	Change "may" to "are"	Thank you, we made this change.
Metti Duressa, on behalf of Ivonne Cameron, CEO of Hepatitis Foundation International	Disability	Those with disabilities have been shown to suffer from many ailments including poor self-rated health obesity smoking and inactivity. Professional competencies is crucial when dealing with the culture of disability and HFI is working towards eradicating this health disparity nationwide.	Thank you for your comment.
Peer Reviewer 2	LGBT	This is a very important point that deserves more attention in the general introduction to this report. What exactly is the difference between patient-centred care and cultural competence and how was this operationalised in this review? The possibility that individualised medicine may be more effective and/or efficient that group-based care (i.e. cultural competence) also requires further exploration in the Introduction and/or Conclusion.	Thank you, we discussed this distinction in more depth in Chapter 1. We are unable to say individualized, or patient-centered care may be more effective, as we did not review those interventions. This is noted in the Limitations section.
Peer Reviewer 4	LGBT	"The few nationally representative surveys that have collected GSM data highlight how different ways of operationalizing sexual orientation effect prevalence statistics, primarily whether or not the population includes only people who self-identify as lesbian, gay or bisexual, or includes people who report same-sex sexual behavior but identify as heterosexual" is an example of where the term 'GSM' is used to refer to both GENDER and sexual minorities but the restive the sentence only addresses sexual minorities	Thank you, to be consistent with the Department of Health and Human Services, we have changed GSM to LGBT throughout the report. We have also made several changes to avoid conflating gender identification with sexual orientation.

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Peer Reviewer 4	LGBT	Some reference should made to the attempts to establish best practices for collecting trans-inclusive data: http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/geniuss-report-sept-2014	Thank you, this is an important report from the Williams Institute with specific recommendations on how to collect gender identity information in surveys. As our report recognizes, having data on disparities should be a precursor to creating interventions to address these disparities. However, evidence for the best way to collect data is beyond the scope of this review.
Peer Reviewer 4	LGBT	The terminology section should include a brief discussion of the problematic conflation of transgender women with MSM.	Thank you, this is an important point, but not the focus of this review. We do use as an example, however, in the health disparities section the effect of lumping transgender male-to-female individuals with men who have sex with men masks the higher rates of HIV infection in this subgroup, particularly among African Americans.
Peer Reviewer 4	LGBT	In the health disparities section, it should be noted (and cited) that trans women have the highest rates of HIV, and the highest rates of HIV-related morbidity and mortality, of all groups.	Thank you, we added a reference to note this disparity.
Peer Reviewer 4	LGBT	another example of conflation of trans identity into sexual orientation: "Since the GSM population, like the straight population,"	Thank you, to be consistent with the Department of Health and Human Services, we have changed GSM to LGBT throughout the report. We have also made several changes to avoid conflating gender identification with sexual orientation.
Peer Reviewer 4	LGBT	Methods: not clear what the phrase "such centers" is referring to	Thank you, we have removed the sentence with "such centers."
Peer Reviewer 4	LGBT	Again, the tremendous HIV-related disparities that transgender women experience are obscured in this section. While the IOM report is cited several times, at least some mention should be made of the fact that one of the recommendations of this report was specific research on transgender health disparities and health care provision.	Thank you for this comment. The discussion section notes the lack of research for numerous subgroups within the broader LGBT populations.

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Commentator & Affiliation	Section	Comment	Response
Peer Reviewer 4	LGBT	Also, when discussing the burden of HIV and the parallel health care structure that arose as a result of the epidemic, the term GSM is not appropriate since non-trans women are largely not included in the population being discussed.	Thank you, to be consistent with the Department of Health and Human Services, we have changed GSM to LGBT throughout the report. We have also made several changes to avoid conflating gender identification with sexual orientation.
Peer Reviewer 4	LGBT	Should also include reference to the literature on transgender people's avoidance of health care due to past experiences of transphobia.	Thank you for the comment. We added a reference to the discussion to address this comment.
Peer Reviewer 4	LGBT	An example of the point being made above, non-trans women are generally NOT associated with HIV so the use of the term GSM is not appropriate here.	Thank you, to be consistent with the Department of Health and Human Services, we have changed GSM to LGBT throughout the report. We have also made several changes to avoid conflating gender identification with sexual orientation.
TEP 1	LGBT	?Typo – should over-identifying be over-identify?	Thank you, we have made this change.
TEP 1	LGBT	Along with the idea of multiple minority status, the concept of "intersectionality" would also be relevant to mention here and elsewhere in the report. See also the important work of Pamela Hayes and the ADDRESSING multidimensional framework of cultural influences:http://www.apa.org/pubs/books/4317138.aspx	Thank you, we do include references to the concept of intersectionality.
TEP 1	LGBT	Additional GSM/LGBT institutional/systemic interventions that are worth mentioning can be found in the following important resources that should be cited: Joint Commission. Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide, August 2011. http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf Human Rights Campaign. Healthcare Equality Index. http://www.hrc.org/campaigns/healthcare-equality-index	Thank you, we added those resources to Appendix E.

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Commentator & Affiliation	Section	Comment	Response
Don Allensworth Davies PhD MSc CPH	LGBT	As the IOM report highlighted I think it is important to explicitly include sexual minority SM elders as a group distinct from SM adults. Their healthcare access and needs are unique and with increased longevity due to effective treatments among those who are HIV we have a growing population of HIV elders which presents new challenges for the healthcare system. Finally while I appreciate AHRQ prioritizing interventions for the areas of SM health which has an established evidence base I also think it is just as important to understand current healthcare utilization and healthcare experiences of SM populations beyond HIVAIDS STIs mental health and substance use to determine where additional disparities might exist as well as interventions to address them. For example there is a growing literature on cancer screening and care among SM populations. Other studies have also been exploring behavioral risk factors and social determinants of health related to chronic conditions such as diabetes and cardiovascular disease in SM populations and how these risk factors may differ from the larger US population.	Thank you for your comment. This review did not explicitly exclude elderly LGBT populations. However, we did not find any articles targeting this population that met inclusion criteria. We do include cancer screening interventions in this review. As noted in the Discussion section, there are many gaps in the current peer-reviewed literature for this population that need further research. We did add a specific statement that identifying additional disparities remains to be done.
Leslie Hausmann	LGBT	non-US studies were included in the disabilities chapter; why are they excluded from the GSM chapter?	Thank you, we decided not to require the same inclusion criteria across population groups. The literature available for each group differed and we adjusted the inclusion criteria if there was little within the US literature. We did include one study from outside the US that we believed could be applied to the U.S. health care systems.
Leslie Hausmann	LGBT	I'm surprised to see this given my previous note about non-US settings being excluded. Was this an expansion applied after the search was conducted? Overall I found the description of what's eligible and what's not to be hard to follow given that there were so many caveats (we weren't going to include this, but then...)	Thank you for this comment. We clarified the inclusion criteria for this chapter.
Leslie Hausmann	LGBT	change "at" to "based on"	Thank you, we made this change.
Leslie Hausmann	LGBT	capitalize "Four", delete "included"	Thank you, we have made these changes.

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Commentator & Affiliation	Section	Comment	Response
Leslie Hausmann	LGBT	insert "among the included studies"	Thank you, we have made this change
Leslie Hausmann	LGBT	I find the use of the noun "included studies" to be hard to follow. By the time you get to this point in the review, it is pretty clear that you are talking about studies included in the review. I think it's ok to just refer to them as "studies".	Thank you, we changed "included studies" to "studies" in three sentences in this paragraph.
Leslie Hausmann	LGBT	insert "whether or not they identify as gay"	Thank you, we added this language.
Leslie Hausmann	LGBT	The use of the MSM acronym is very inconsistent. Consider using it all the time or known of the time.	Thank you, we use the MSM acronym only when it is used by the authors of an included manuscript.
Leslie Hausmann	LGBT	Change "heterosexual" to "non-gay"	Thank you, we made that change.
Leslie Hausmann	LGBT	what age was the target population? I thought age would be important given the previous sentence that talks about "across the GSM age continuum."	Thank you, we corrected the previous sentence to de-emphasize the age component.
Leslie Hausmann	LGBT	acronyms previously defined	Thank you, we made this change.
Leslie Hausmann	LGBT	provide citations. I thought you were saying that you included 2 additional studies but then realized you were talking about 2 already in the table.	Thank you, we added citations to this sentence
Leslie Hausmann	LGBT	shouldn't there be 2 citations here?	Thank you, we added a ciation to this sentence
Leslie Hausmann	LGBT	add language "to evaluate the impact of curricula"	Thank you, we made this change.
Leslie Hausmann	LGBT	what items are you referring to here?	Thank you, we will list the four items that were significantly changed in this sentence.
Leslie Hausmann	LGBT	insert "the"	Thank you, we made this change.

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Leslie Hausmann	LGBT	insert "the"	Thank you, we made this change.
Leslie Hausmann	LGBT	change verbs to past tense in sentence	Thank you, we made this change.
Leslie Hausmann	LGBT	insert "the"	Thank you, we made this change.
Leslie Hausmann	LGBT	This study really doesn't fit into the review given that it focuses entirely on patients, and does not measure any outcomes pertaining to patients' experiences in the healthcare system.	Thank you for this comment. This study was included because the intervention was led by a clinical social worker.
Leslie Hausmann	LGBT	change "manuscript" to "review"	Thank you, we changed this sentence. It now reads: "Over 6,800 articles were reviewed, resulting in 11 included studies, only five of which were RCTs."
Leslie Hausmann	LGBT	remove the word "included"	Thank you, we made this change.
Leslie Hausmann	LGBT	remove "included study" add "sample"	Thank you, we made these changes.
Leslie Hausmann	LGBT	remove "included" add "the"	Thank you, we made this change.
Leslie Hausmann	LGBT	acronym previously defined	Thank you, we made this change.
Leslie Hausmann	LGBT	remove the word "included"	Thank you, we made this change.
Leslie Hausmann	LGBT	acronym previously defined	Thank you, we made this change.

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Commentator & Affiliation	Section	Comment	Response
Metti Duressa, on behalf of Ivonne Cameron, CEO of Hepatitis Foundation International	LGBT	Data on Gender and Sexual Minority Populations is sorely lacking and it is crucial that we address the distinct health and healthcare needs concerns and disparities of these groups. The most well-studied health disparity in the GSM population is HIVAIDS incidence and prevalence. Men who have sex with men are 44 times more likely than heterosexual men to be newly diagnosed with HIV and differences in all-cause mortality rates between gay and heterosexual men are largely attributable to this disparity. This concerns HFI because we touch base with HIV-Hepatitis coinfection and ways we can address this marginalized group in a culturally sensitive way.	Thank you for your comment.
Rej Joo, National LGBT Cancer Network	LGBT	Positives: This research was exceptionally thorough in forming the study inclusion/exclusion criteria especially when it comes to excluding individual tailored interventions and only including community tailored interventions. We really appreciated the background information about the LGBTQ population and the discussion around the evolving language of LGBTQ communities. Suggestion: On page 65 inside the table under GSM clinical box Knowing what problems may be associated with sexual behaviors. Would it be more trans inclusive to add ...and/or gender transition after ...sexual behaviors So it would read Knowing what problems may be associated with sexual behaviors and/or gender transition.	Thank you, to be consistent with the Department of Health and Human Services, we have changed GSM to LGBT throughout the report. We have also made several changes to avoid conflating gender identification with sexual orientation.
Peer Reviewer 2	Race/ Ethnicity	Also, it isn't clear to me why some located studies were excluded. For example, some if not most of the papers listed in the 'not on topic' section appear to be exactly on topic?	Thank you for the comment. We have further clarified this exclusion category.
Peer Reviewer 2	Race/ Ethnicity	However, such adjustments are not always advisable, see, for example: Glickman et al. 2014. False discovery rate control is a recommended alternative to Bonferroni-type adjustments in health studies. Journal of Clinical Epidemiology 67 (2014) 850-857.	Thank you for the comment. The referenced article was speaking to hypothesis-generating studies, while we believe, from reading the Pan 2011 text, the study was intended to test hypothesis. We have removed the language regarding Bonferroni adjustments from the main text, as it remains a matter of interpretation. We have left the text as a note to the table for readers who are interested in greater detail.

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Peer Reviewer 2	Race/ Ethnicity	Structural competency is also an emerging term that may be worth mentioning: Metzl, J. M. and H. Hansen (2014). "Structural competency: Theorizing a new medical engagement with stigma and inequality." Social Science & Medicine 102: 126-133.	Thank you, we added this reference to the Chapter introduction.
TEP 1	Race/ Ethnicity	The authors may also wish to cite the following important report: Goode T, Dunne MC, Bronheim SM.The Evidence Base for Cultural and Linguistic Competency in Health Care, Commonwealth Fund, October 2006.	Thank you, we have updated our working definition of cultural competence for this population.
TEP 1	Race/ Ethnicity	The important work of Drs. Camara Jones and Nancy Krieger on racism and health should also be cited: http://www.acphd.org/social-and-health-equity/presentations-and-resources/camara-jones.aspx http://www.minority.unc.edu/sph/minconf/2008/keynote.cfm	Thank you, these individuals are doing important work on racism and health. We cited Camara Jones in the Chapter introduction.
TEP 1	Race/ Ethnicity	The Cross et al. definition provided of cultural competence is an organizational/systemic one but as noted above, most of the literature cited and discussed focuses more on health care providers' behaviors and the patient-provider relationship and very little on clinical systems or the health care organization per se (see various Joint Commission, NQF, NICHQ, et al cultural competency reports). The evidence review appears to be incomplete.	Thank you, we have updated our working definition of cultural competence for this population.
TEP 1	Race/ Ethnicity	Regarding studies of provider educational interventions, the authors should also consider including the following: Kutob RM, Senf JH, Harris JM Jr. Teaching culturally effective diabetes care: results of a randomized controlled trial. Fam Med 2009;41(3):167-74. https://www.stfm.org/fmhub/fm2009/March/Randa167.pdf Kutob RM, Bormanis J, Crago M, Senf J, Gordon P, Shisslak CM. Assessing Culturally Competent Diabetes Care With Unannounced Standardized Patients. Fam Med 2013;45(6):400-408. http://www.stfm.org/FamilyMedicine/Vol45Issue6/Kutob400	Thank you for the manuscript recommendations. These two articles did not meet our inclusion criteria. Kutob et al., 2009 was excluded because patient outcomes were not part of study design nor assessed; Kutob et al., 2013 was not an intervention study.

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Commentator & Affiliation	Section	Comment	Response
TEP 1	Race/ Ethnicity	A number of important online/e-learning courses have also been developed that would be worth citing. Empirical results from some have been presented at national meetings, workshops, and in the “gray literature."	Thank you for the comment. The review inclusion criteria included English publications in the named databases. Using peer-reviewed reports allows the review team somewhat better confidence in study protocols with which to assess risk of bias, and study designs that may lead to some strength of evidence. It is unfortunate the literature for this review was too sparse and of such high risk of bias that we were not able to assess the evidence base beyond “insufficient.” We understand and appreciate your highlighting the discrepency between the plethora of grey literature, trainings and tools, and the evidence for the interventions.
TEP 3	Race/ Ethnicity	On page 43 the term should be racial/ethnic and not race/ethnic.	Thank you, we changed "race/ethnic" to "racial/ethnic."
TEP 3	Race/ Ethnicity	For the racial and ethnic population chapter, there do not appear to be any studies that focus on or specifically include the justice-involved/ formerly incarcerated/reentry population. This population really should have been included as a unique chapter. However if that was not possible, this group should have been interwoven into the racial/ethnic chapter, as disproportionate numbers of minorities are in the jail/prison system. This is a group for which cultural competence is extremely important. This population should be included and acknowledged. Minimally this population should be mentioned in the research directions section	Thank you, persons who were justice involved was not a focus population for this review. However, a study of a culturally competence intervention for a racial or ethnic priority population that also focused on the justice involved population would have been included, provided it met all other inclusion criteria. Our search did not reveal such a study.
Public Anonymous	Race/ Ethnicity	Under Study Selection what does consensus adjudication mean. In the spirit of improved health literacy is there another simpler term/phrase that would work here? Or can a short definition be added?	Thank you, in this case consensus adjudication refers to a process by which the authors discussed the inclusion or exclusion of a manuscript that did not clearly meet previously established criteria and reached an agreement on how to proceed. We revised the sentence to “Differences of opinion regarding eligibility were resolved through consensus.”

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Public Anonymous	Race/ Ethnicity	Under Study Selection why is U.S. setting a requirement for this race/ethnic search strategy but not for the disability search strategy	Thank you for the question. When establishing the protocol, the review team, with input from the Technical Expert Panel, deemed the differences in race/ethnic communities and relationships potentially different enough from other countries to challenge generalizability. There was also the expectation that the literature for this population of interest would be more robust since the cultural competence concept was initially created for this group and has been of interest for a longer time period.
Public Anonymous	Race/ Ethnicity	Under Literature Search Results it is difficult to believe that No studies of the American Indian and Alaska Native AIAN population met the inclusion criteria. Did you check with the Indian Health System database	Thank you for your comment. In the databases searched for this review, using the published search algorithms, we found only 1 study for the AIAN population. The MeSH term specific for this population was used in the search algorithm.
Public Anonymous	Race/ Ethnicity	Under Discussion yes racial/ethnic characteristics often overlap with sociodemographic characteristics that increase likelihood of disparities but not always. There have been studies done to show that wealthy educated African Americans can still experience poorer health outcomes than poor uneducated white populations. Unnatural Causes PBS Documentary SeriesEpisode 2 When the Bough Breaks. See link httpwww.unnaturalcauses.orgepisodedescriptions.php	Thank you for this comment.
Asian & Pacific Islander, American Health Forum	Race/ Ethnicity	Refer to letter that includes data on health disparities within the AA and NHPI populations. The letter describes a number of community-level interventions with which the Forum is involved.	Thank you for this letter.
Leslie Hausmann	Race/ Ethnicity	add apostrophe	Thank you, we made this change.

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Commentator & Affiliation	Section	Comment	Response
Leslie Hausmann	Race/ Ethnicity	add a space between "only" and "and"	Thank you, we made this change.
Leslie Hausmann	Race/ Ethnicity	This makes it sound like trying to culturally tailor anything is a fool's errand because there too many different groups and what works for one may not work for any others. Is that the message the authors were intending to send?	Thank you, we revised the sentence to suggest that the issue of generalizability of culturally tailored interventions remains unknown until tested. The sentence now reads: “Whether an intervention delivered to and/or tailored based on a sample population can be generalized to others within the same race or ethnic group, such as Hispanic Americans living in different geographic regions or with different levels of acculturation, remains unknown.”
Leslie Hausmann	Race/ Ethnicity	I don't see this as a bad thing. (Reference "Often, interventions aim to address multiple types of barriers to healthcare and health outcomes, rather than isolating cultural competence factors.")	Thank you, the authors did not intend to describe interventions that address multiple types of barriers to heatlhcare and health outcomes as "bad." However, it makes assessing the cultural competence component of the intervention more challenging. We added some language to clarify this point.
Leslie Hausmann	Race/ Ethnicity	remove "included"	Thank you, we made this change.
Leslie Hausmann	Race/ Ethnicity	This is difficult to parse (reference: "For instance, Alegria et al. evaluated the effectiveness of six to eight session cognitive behavioral therapy and care management intervention for low-income Latinos delivered via telephone versus face-to-face compared with usual care.")	Thank you, we changed this sentence. It now reads: "For instance, Alegria et al. compared the effectiveness of six to eight sessions of cognitive behavioral therapy and care management for low-income Latinos delivered by telephone versus inperson; the intervention also included a usual care arm."
Leslie Hausmann	Race/ Ethnicity	insert "but not both"	Thank you, we did not make this change as it alters the meaning of the sentence.

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Leslie Hausmann	Race/ Ethnicity	I don't completely follow this paragraph. Are the authors saying that they excluded studies grounded in social science theories, or did they include such studies but did not delve into the theory underlying the studies? One of the studies that was included (160) is firmly grounded in social psychology, so it seems like they included studies that met the inclusion criteria, even if they had a social science conceptual framework. Earlier I thought the authors pointed out that there is no consensus on a definition of cultural competence or on a framework for how to improve it, so why are interventions that happen to draw from social sciences rather than medical-based cultural competence literature being called out in the limitations section?	Thank you, we have revised this paragraph. We have added the sentence: "While the interventions may indeed have been consistent with cultural competency models, study authors may or may not have intended the interventions be evaluated as cultural competence."
Metti Duressa, on behalf of Ivonne Cameron, CEO of Hepatitis Foundation International	Race/ Ethnicity	HFIs aim is to address cultural appropriateness and healthcare disparities among ethnic groups such as Native Americans Latinos and African Americans. Minorities are more likely to lack health insurance coverage and they are disproportionately covered by public programs like Medicaid where reports of insurance-based discrimination being treated unfairly by health care providers based on enrollment in public insurance or a lack of insurance are higher. HFI is mindful of the plight of these minority groups and make it our mission to assist them in finding clinics that benefit them.	Thank you for your comment
Public Mallika Rajapaksa	Race/ Ethnicity	Even though there are no studies addressed culturally competent care specifically for children as mentioned in the report, it is more useful to address the culturally competent care for elderly patient population by race/ethnicity in this section	Thank you for your comment. Studies of the elderly from racial and ethnic minority populations would have been included if they met all other criteria.
TEP 1	Models	The authors have lumped together broader theoretical/ethnographic models of cultural competence (e.g., Leininger's Sunrise Model, cultural competence continuum model) with practical clinical interviewing mnemonics/frameworks/concepts (e.g., LEARN, CRASH, ETHNIC, BATHE). It would be important to define Models (with a big M) and models (with a small m) and disaggregate these as they serve different purposes.	Thank you for the comment. We agree with the reviewer that using theoretical versus practical clinical lines is one possible way to categorize the models. We have chosen use to categorize by model target (patient or provider) for consistency with how cultural competence interventions are designed to target patients or providers.
TEP 1	Models	As noted above, a number of important organizational/systemic cultural competency frameworks are not included in the Table that can be found in the important literature missing from this review (e.g., the Lewin Group, National Quality Forum, et al). The statements that "interventions at the system level are also rare" and	Thank you, we have changed these two sentences to emphasize the scarcity of systematic interventions evaluated in the peer reviewed literature, but that many

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		“the literature was also silent on system level concerns ….” are incorrect and not supported when this additional literature is examined. For example, there are many examples provided in the recently released OMH CLAS Blueprint with the annotations relating to the various CLAS Standards.	recommendations have been published by leading organizations: "…peer reviewed published evidence for the effectiveness of interventions at the system level are also rare," and "The published literature was also silent on system-level concerns."
TEP 1	Models	In Table 23, it is possible to fill in the Physical Environment/Race Ethnicity box - waiting rooms that include magazines in the languages of patients being served, artwork/photos that are culturally tailored and relate to communities in local service area; the Cultural Mores/Disability box – see disability culture articles, addressing stigma; and the Cultural Mores/GSM box – addressing LGBT culture issues and the diversity within the population – see Joint Commission and HRC Healthcare Equality Index.	Thank you for the comment. We believe the items mentioned contribute to the Social Environment aspect, and constrained the Physical Environment aspect to the physical structure of the site. Similarly, the Cultural Mores of racial/ethnic groups are qualitatively different and consider the Social Environment aspect to cover more nuanced diversity issues that arise from groups that would otherwise be considered within the American culture.
TEP 1	Models	This reviewer finds particularly problematic the authors’ statement that “It may be time to replace the ‘cultural competency’ term with one that focuses on external structural factors that contribute to disparities.” They have also oversimplified the concept of “cultural competence” and described it as mainly being about the “attributional dimension” when indeed a great deal of the current work especially in the area of organizational/systemic cultural competence also focuses on the “relational dimension.” Rather than an “either/or” approach, it would be much more fruitful and productive to pursue a “both/and” strategy. That is, instead of replacing the term cultural competency, why not enhance, expand, and synergize it with recent perspectives, research, and praxis relating to: upstream thinking, structural competency, and cultural health capital.	Thank you for your comment. We eliminated the language in Chapter 5 that suggests the replacement of the term. Cultural competence is an evolving term. That adds a level of definitional complexity to doing a systematic literature review. For the purposes of this review, the terms upstream thinking, structural competency, and cultural health capital were not included in the search.

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TEP 1	Models	In terms of future Research Directions, the authors are strongly encouraged to examine and cite the following recently released NIH document that may help in developing an evidence-based for cultural competence interventions: Kagawa-Singer, K, Dressler, WW, George, SM, Elwood, WN, with the assistance of a specially appointed panel. (2015, March). The cultural framework for health: An integrative approach for research and program evaluation. Bethesda: NIH Office of Behavioral and Social Sciences Research. http://obssr.od.nih.gov/pdf/cultural_framework_for_health.pdf	Thank you, this report provides specific recommendations to conducting culturally informed research.
TEP 1	Models	In terms of legislative mandates, the authors may also wish to cite the following:	Thank you, policy interventions are outside the scope of this review
TEP 1	Models	It would also be appropriate to mention accreditation, regulatory, and quality of care requirements from organizations such as the Joint Commission, National Quality Forum, CMS, et al.	Thank you, policy interventions are outside the scope of this review
TEP 1	Models	Another Chapter is needed that reviews and presents the evidence relating to KQ5!!!	Thank you for the comment. KQ5 is a topic for which there is a lot of grey literature but not a lot of peer reviewed literature. As this is a systematic literature review of published literature, and not a technical brief, we do not think that KQ5 warrants its own chapter. The chapters are intended to stand alone and can be read in any order the reader prefers.
TEP 2	Models	I recommend putting “Cultural Competence Model” from Chapter 5 into Chapter 1 since it informs the understanding of chapters 2-4.	Thank you, we have left the text order in its original order. As noted in Chapter 5, the cultural competence model had been intended to inform the review process and provide an overarching framework. However, the identified literature was so patchy and sparse, the original plan did not actually serve the review process. Thus, we left it for broader informational purposes in the Chapter 5.

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TEP 2	Models	The first three sentences of the first paragraph under "Differences Among Populations" seem to be more well-suited for the section above it.	Thank you, we think the language works well in its current location. We see that the first three sentences can be read as an introduction and link to a new section. However, the overarching themes section of Chapter 5 is structured with introductions following rather than preceding the identifying headers. Leaving the three sentences where they are leaves the parallel structure for the report in place.
TEP 2	Models	You might consider also including a table like Table 23 that summarizes examples of "within population" differences.	Thank you for the comment. We agree that is an interesting topic. We do note in the paragraphs that introduces the Table that there are within-populations differences. However, even generalized within-populations differences leads to a very long table, and so choose to not include one.
TEP 3	Models	Office of Minority Health should be HHS Office of Minority Health. Authors also need to reference the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) minimally in the intro and conclusion. This is a major HHS policy related to cultural competence/culturally and linguistically appropriate services.	Thank you, we recognized the CLAS standards and identify HHS and the Office of Minority Health.
Don Allensworth Davies PhD MSc CPH	Models	I would strongly recommend adding a section on intersectionality as part of this report. To the extent that a person may be a member of more than one minority group can have a profound impact on healthcare access and their experience of care. While I saw that you referenced one of Dr. Bowlegs articles on intersectionality I think that this report would be greatly strengthened by exploring this area more indepth as part of its own section. This would also provide an opportunity to identify areas of synergy among the different minority groups described in the report which in turn would also help to identify areas for multidisciplinary collaboration as well as prioritize disparity initiatives. To the extent that a single intervention or health initiative can help to reduce disparities across multiple minority groups represents a more efficient use of scarce resources and the application of intersectionality concepts as part of the final analysis can help to identify these opportunities.	Thank you, we agree with the importance of intersectionality and we do include references to the concept. Intersectionality is also mentioned throughout the review were relevant. However, while important, intersectionality is not the focus of this review, and we chose to not include an additional section in order to not detract from the main messages of the report.

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Leslie Hausmann	Models	move "examined in this report" before colon	Thank you, we made this change.
Leslie Hausmann	Models	move period outside of parentheses	Thank you, we made this change.
Leslie Hausmann	Models	this citation isn't linked (reference to citation #239)	Thank you, we have checked all citations for proper linkages.
Leslie Hausmann	Models	remove the word "however"	Thank you, we made this change.
Leslie Hausmann	Models	remove the word "the"	Thank you, we made this change.
Leslie Hausmann	Models	you lost me here. I think unconscious bias plays a role in how providers interact with members of GSM groups and racial and ethnic minority groups.	Thank you for the comment. We have revised the sentence for clarity. It now reads: "For members of sexual minority populations, which are more invisible, cultural competence interventions may focus on reducing heterosexual bias among providers; for example, providers may not know that the patient is an LGBT person. In contrast, provider bias to racial and ethnic minority populations is immediate and based on characteristics perceived by the provider."
Leslie Hausmann	Models	Overall, I think the conclusion section reads like a 2-sentence summary of each section of the last chapter. It doesn't really convey a few important take-home points beyond what has already been written.	Thank you for your comment. We have revised the conclusion section to integrate the messages across the chapters. However, some duplication is to be expected. The function of the final conclusion is in part to consolidate the take-home points that are spread throughout the four chapters that report results and overarching themes.

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Commentator & Affiliation	Section	Comment	Response
Rej Joo, National LGBT Cancer Network	Models	It was great to hear that this research recommends that future research and practice to move towards cultural empowerment and cultural humility framework or structural equity-focused interventions. Also the conceptual comparison of relational dimension vs. attribute dimension to make this point was very interesting	Thank you for this comment.
TEP 1	General	It would be easier to read and make more sense to reorder and renumber the Chapters and discuss the findings relating to KQ1 at the beginning of the report (rather than at the end), followed then by KQ4 (which has a longer history of research), followed then by the more recent extension of cultural competence perspectives to KQ2 and KQ3. There was also very limited discussion of KQ5 which merits it own chapter.	Thank you for the comment. KQ5 is a topic for which there is a lot of grey literature but not a lot of peer reviewed literature. As this is a systematic literature review of published literature, and not a technical brief, we do not think that KQ5 warrants its own chapter. The chapters are intended to stand alone and can be read in any order the reader prefers.
TEP 1	General	The authors also have not discussed or cited much of the important and extensive research related to addressing organizational/systemic cultural competence by groups/ individuals such as the Lewin Group, Georgetown National Center for Cultural Competence, Andrulis, Maldonado, Dreachslin, et al. (see below) While this work may not have taken the form of RCTs, prospective cohort studies, or observational studies, it should at least have been mentioned and discussed in the body of the text, tables, and reference list as well as mentioned in terms of future needed research studies.	Thank you for the comment and the grey literature resources. The current study only includes peer reviewed literature.
TEP 1	General	The authors also take a leap beyond the evidence and (from this reviewer's perspective) prematurely call for replacing the term cultural competence (which they have over-simplified and inadequately conceptualized, especially at the organizational/systemic level), instead of looking for ways to creatively interface and synergize cultural competence with other emerging work in the areas of "upstream thinking," "structural competency," "cultural health capital," and "health equity." This does a disservice to the extensive ongoing work in the field of cultural competence and doesn't take account of a host of major initiatives from organizations including the Joint Commission, National Quality Forum, CMS, American Hospital Association Equity of Care, et al that are not mentioned. This is discussed in more detail below.	Thank you for the comment. We eliminated the language in Chapter 5 that suggests the replacement of the term "cultural competence".

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TEP 1	General	A disclaimer statement should be included that the ideas and opinions expressed in this reports are those of the authors and do not necessarily represent those of the members of the Key Informants, Technical Expert Panel, or Peer Reviewers or the organizations that they are employed by or with whom they are affiliated.	Thank you for the comment.The report does include a disclaimer in the front matter on pages iv and v that "study questions, designs, methodologic approaches, and/or conclusions do not necessarily represent the views of individual" key informants, technical and content experts, or peer reviewers.
TEP 1	General	As mentioned above, would suggest changing the storyline and chapter order to present findings relating to KQ1, KQ4, KQ2, KQ3, and KQ5 in this order.	Thank you for the comment. KQ5 is a topic for which there is a lot of grey literature but not a lot of peer reviewed literature. As this is a systematic literature review of published literature, and not a technical brief, we do not think that KQ5 warrants its own chapter. The chapters are intended to stand alone and can be read in any order the reader prefers.
TEP 1	General	The authors are encouraged to further define and make a clearer distinction between health disparities, health care disparities, and equity in health and health care (see IOM and Healthy People 2020 reports) both upfront and in each of the subsequent chapters. The evidence for the potential role of cultural competence in reducing both types of disparities should be more carefully discussed as most cultural competence researchers are aware that addressing health disparities and health equity requires a much broader and multifactorial approach beyond just clinical care and cultural competence interventions.	Thank you. The scope of the current review is focused on cultural competence limited to disparities in health care.
TEP 1	General	The definition of "interventions at the systems level" being used is extremely limited and leaves out a great deal of the ongoing cultural competency work relating to organizational transformation, quality improvement, patient safety, and other structural interventions.	Thank you for this comment and the list of recommendations from prominent organizations. These resources have not been tested in the peer reviewed literature.
TEP 2	General	Discussion/ Conclusion: There could be a more clear and strong statement about the specific research that remains.	Thank you for this comment. It is not clear to the authors to what specific research needs the reviewer is referring.

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Commentator & Affiliation	Section	Comment	Response
Public Anonymous	General	Given the continued browning of America where communities of color are becoming the majority in parts of California and more and the 05 yr old population is the most racially and ethnically diverse population the US has ever experienced our Office of Equity and Inclusion would recommend beginning with racial and ethnic minority populations first among the 3 priority populations.	Thank you for the comment. The chapters are intended to stand alone and may be read in any order.
Public Anonymous	General	Literature Search Strategy. Databases searched seem limited. Interesting that many of the disability interventions highlighted were from outside of the U.S. Did you consider including evidence-based practice registries and databases including Substance Abuse and Mental Health Services Administration SAMHSA and/or other social work or public health related ones focused on health care which may have more content experiences re culturally responsive interventions Especially since under research directions in chapter 5 the report states Cultural competence research for the wider priority populations will require interdisciplinary approaches.	Thank you for the comment. This review was limited to peer-reviewed publications.
Public Anonymous	General	Given your focus on patient/provider interaction and the system of care surrounding that interaction can you clarify if you included interventions involving community health workers CHWs and qualified/certified health care interpreters HCIs as members of the health care provider team especially given these national and local movements in Oregon's health systems transformation efforts. If CHW and HCI interventions were excluded what was the reasoning	Thank you for your comment. Interventions involving community health workers and qualified certified health interpreters would have been included if they helped patients connect with the formal healthcare system or were associated with the formal healthcare system and if the study was designed to test the cultural competence elements .
Don Allensworth Davies PhD MSc CPH	General	Overall thank you for undertaking this review and report. Has AHRQ considered conducting analyses of the Medical Expenditure Panel Survey MEPS by sexual orientation or gender identity If I remember correctly MEPS is linkable to the National Health Interview Survey NHIS and now that NHIS has again added sexual orientation as part of its survey I am wondering despite the lower cell counts for sexual orientation if there might be an opportunity to learn more about service utilization among SM populations via MEPS to help strengthen the evidence base and inform future interventions.	Thank you for the suggestion for conducting analysis of the MEPS by sexual orientation. Such an analysis is beyond the scope of this review. However, we notified the AHRQ/MEPS team of this opportunity.

Source: https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2206
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Mallika Rajapaksa	General	California Department of Public Health, Office of Health Equity (OHE) addresses disparities and cultural competence among the “Vulnerable communities” including women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities, or combinations of these populations. It would be nice to expand the disparities discussion in the report to include some of these communities in the three priority population groups so as to address disparities and cultural competence.	Thank you for your comment. This review is limited in scope to individuals with disabilities, racial or ethnic groups, and LGBT communities. Certainly, these populations overlap and intersect with each other and the other "vulnerable communities" mentioned in your comment. We would not have excluded literature that explored an intersection between one of the populations you mentioned and the priority populations identified for this review.
Peer Reviewer 3	General	General Comments: Report is a good summary of work to date, but does not incorporate new frameworks that look beyond the cultural competence construct.	Thank you, we were not asked to go beyond cultural competence for the purposes of this review
Beth Kingdon	General	I recommend emphasizing what it means to be culturally competent at all levels of health care ranging from one on one conversation between a provider and patient the patients overall experience in the clinical setting and to the infrastructure of the individual institution or health system. Health disparities and health equity-in-equity are not the same concepts at least to my reading it appears that these concepts are used interchangeably throughout the document. Health disparities generally refer to differential rates of morbidity and mortality among different population groups for example woman have higher rates of breast cancer than men and the practice it generated tended to focus on diseases and risk factors. Health inequity refers to unnecessary and avoidable differences that are considered unjust see Expanding the Boundaries Health Equity and Public Health Practice published by National Association of County City Health Officials in May 2014.Thank you for undertaking this extensive review on this critical topic.	Thank you for this comment. We agree that health disparities and health equity/inequity are not the same concepts and we attempted to make this distinction in the introduction and throughout the report.
Leslie Hausmann	General	Congratulations on creating a comprehensive and informative review of current evidence on the types of interventions used to increase cultural competence in healthcare settings and their effects on patient and provider outcomes. The reviews inclusion of studies focused on delivering culturally sensitive care for patients with disability from gender and sexual minority groups and from racial and ethnic minority groups provides the field with a wonderful	Thank you for your comment.

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		resource describing the various intervention strategies that have been tried with diverse groups of patients. It is clear from the review that there is much more work to be done to determine whether cultural competence training or other types of interventions per se can improve overall healthcare quality and increase equity of care across groups. However after reading the review I am left with the feeling that if the field stays on its current trajectory it will never be able to produce enough studies to provide sufficient high-quality evidence that allows strong conclusions to be drawn about whether interventions can improve the cultural competence of healthcare systems. It seems from the review that most existing studies fall short in that they either test cultural competence interventions that are too narrow in focus e.g. they focus on a narrowly defined group so the results arent generalizable or are too broad in scope e.g. interventions address multiple barriers to care without isolating the cultural competency components. I find it difficult to reconcile those two critiques because for a single intervention to increase culturally competent care for a diverse set of patients it needs to be broad enough in scope that it addresses a diverse set of barriers to receiving and/or delivering culturally sensitive care. I think the authors recommendations that the field move in the direction of focusing on structural barriers to care across diverse groups will help to improve the reach of future interventions to improve equity. Although focusing on cultural competency of individual providers or tailoring certain aspects of care for patients with unique needs may be a component of future interventions they will likely need to be part of a bigger movement to change the structure of the healthcare system to foster inclusiveness and enable providers to provide equitable and culturally sensitive care to all patients. I hope this review inspires the field to pursue the goal improving the cultural competence of healthcare systems by examining the current systems that are delivering healthcare acknowledging that system characteristics make the system easier to navigate for some groups than for others and taking steps to change the system so it is more welcoming and effective for all.	

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Rej Joo, National LGBT Cancer Network	General	This is an excellent draft. Im part of the National LGBT Cancer Network and we have been working on building LGBTQ cultural competence resources including a LGBTQ CC training manual and a LGBTQ CC tool kit see link below httpwww.lgbtcultcomp.orghttpcancernetwork.orgdownloadsbestpractices.pdfThis research is very important in the work that we do and were very excited to see the final version of this THANK YOU.	Thank you for the comment and the link to useful training resources.
Susan Moscou	General	The term cultural competence is problematic. We do not want people to think they can become competent in understanding culture particularly because culture is dynamic and is mediated by class race gender and education. Additionally cultural competence has facilitated stereotypical assumptions about groups. Because this document does acknowledge the roles of racism sexism classism and so forth we need a term that is different so that people rethink their understandings of culture. Many have used the term cultural congruence.	Thank you for your comment. We make similar points in Chapter 5.