

Cultural Competence in Health Care Systems: A Case Study

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Abstract

This study studied cultural competence training needs in a health services system in California. Results indicated that the major training needs were related to (1) cultural factors that affect consumers' access to services, (2) ethnic and cultural beliefs, traditions, and customs, (3) training for interpreters, and (4) cross-cultural communication. Significant differences were found in regard to administrator and staff participation in cultural awareness activities, perception of the work environment as culturally competent, perception of culturally-related barriers, and perceived training needs. The findings support the importance of a continuous assessment of the educational needs of employees regarding cultural competence.

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Introduction

US Census Bureau (2002) data show that the US is experiencing one of the fastest transformations in terms of its ethnic and racial composition. According to population analysis and projections the largest increases are and will continue to be among members of under-represented groups which may or may not be fluent in the English language.

The increasing diversification of the US population provides public health care systems with unique challenges and opportunities to address the health care needs of individuals and families from racially, ethnically, culturally, and linguistically diverse groups (Goode & Cohen, 1999; Yee, Mokuau, & Sehwan, 1999). Continuing the federal government's commitment to equal access to program and services quantified in Title VI of the Civil Rights Act of 1964 which mandates that no person in the United States should be discriminated under any program or activity receiving federal financial assistance (Goode & Cohen, 1999), the Office of Minority Health has released its Culturally and Linguistic Appropriate Services (CLAS) Standards designed to create, among other things,

culturally competent systems of care which acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, and it is vigilant towards the dynamics that can result from cultural differences (Cross, Brown, Dennis, & Isaac, 1998; Settles, 2003). Health educators have an inherent responsibility in assisting organizations comply with the standards and be leaders in the development and implementation of programs which are culturally competent.

The National Center for Cultural Competence (NCCC) indicates that culturally competent primary health care systems are necessary to respond to current and projected demographic changes in the United States. According to the NCCC culturally competent health care systems can eliminate long-standing disparities in health status of people of diverse racial, ethnic, and cultural backgrounds; improve the quality of services and health outcomes; meet legislative, regulatory, and accreditation mandates; gain a competitive edge in the market place; and decrease the likelihood of liability/malpractice claims (Goode & Cohen, 1999). Why should health care systems invest in developing a culturally competent workforce?

Health care systems are responsible for the quality of care, comprehending the client's cultural beliefs and crafting them into the treatment or prevention plan becomes critical to providing competent services (National Alliance for Hispanic Health, 2000). A culturally competent public health system of care acknowledges and incorporates the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics that can result from cultural differences and ethnocentric approaches, the expansion of cultural knowledge, and the adaptation of services that meet culturally unique needs (Cross, Brown, Dennis, & Isaac, 1998).

Providing culturally competent services extends beyond merely supplying medical interpretation. Providing culturally competent services requires that public health systems make a concerted effort to select, train, and support key outreach staff which can bridge the gap between ethnic communities and health institutions (Jackson-Carrol, Graham, & Jackson, 1996). Cultural competence is more than overcoming language barriers; it must address cultural and societal barriers to receiving and accessing health services. These services must address the barriers clients face as well as communication or behavioral patterns and culturally defined notions of illness, symptomatology, and acceptable treatment modalities (Goode, Sockalingam, Brown, & Jones, 2000).

Providing culturally competent services requires that public health systems make a concerted effort to select, train, and support employees to deal with cultural differences and bridge the gap between ethnic communities and health institutions (Jackson-Carrol, Graham, & Jackson, 1996) realizing that cultural competence is developed over time through training, experience, guidance, and self-evaluation. Therefore, professionals who provide services to diverse populations need to learn about their clients' ethnicity, the cultural orientation of the organization they are working with, and the environment that shape their behaviors and attitudes toward the people they serve (Hernandez & Isaacs, 1998).

To-date limited research has been conducted in the area of organizational self-assessment in terms of cultural competence. Among the many reasons for this deficiency is the lack of uniform definition for what is considered cultural competence (see Luquis and Perez, 2005 for a discussion on this topic). According to the U.S. Department of Health and Human Services Office of Minority Health (Fortier & Taylor, 1999), there is no national consensus on the definition of cultural competence, and what constitutes a culturally competent health professional is also subject to varying definitions. What is clear, however, is the need for public health systems to move from being "culture blind/aware," to being "cultural competent."

The lack of self-assessments and the continued perception in some areas that cultural competence is a "frill" has resulted in the lack of a standard curriculum, or a nationally accepted certification or credentialing for training in cultural competence. Thus, a major challenge is to determine the scope of training needed related to cultural competence by employees in health organizations (Fortier & Taylor, 1999) is the self-assessment required by the CLAS. A number of models have been proposed for developing cultural competence and sensitivity (Bell & Evans, 1981; Borkan & Neher, 1991; Campinha-Bacote, 1994). However, before any of those models can be employed, public health agencies must make an inventory of their commitment and standing in terms of cultural competence. This is an area where health educators can play a key role as they implement responsibilities two to five promoted by the Competencies Update Program Model.

Methods

The purpose of the study was to identify the training needs of workers in a public health agency. Training needs were assessed by determining the levels of knowledge, participation in cultural awareness activities, perception of the work environment as culturally competent, perception of culturally-related barriers, and perceived training needs. This

study included an analysis of the differences in training needs for staff and administrators.

Instrument

The survey instrument used in this study was based on the cultural competence framework developed by the Arizona Department of Health Services (1995). It included six questions related to demographic and seven sections dealing with knowledge levels related to trainings on cultural competence available at the workplace. The second section assessed attitudes toward immigrant minorities, additional pay for bilingual employees, employees speaking in another language, employees being treated with respect regardless of their heritage, and having to deal with cultural issues in the workplace.

The third section included four questions that assessed workers' participation in culturally-related activities including participation in formal training and community activities. The fourth section identified the characteristics of the work environment including the presence of contract or in-house interpreters. The fifth section included nine items to determine culturally-related barriers to access services. The sixth section involved the identification of training needs related to cultural competence, through eight questions, as suggested by CLAS (Culturally and Linguistic Appropriate Services) standards.

The last section involved an open-ended question to identify the training needs on cultural competence as perceived by the respondents. In this section, participants were given the opportunity to freely list the topics related to cultural competence of relevance for their practice.

Instrument Development

The survey was pre-tested on a sample of 20 employees which included thirteen staff and seven administrators with a 75% return rate. The response rate in the staff job category was 84% (n=11), and in the administrator job category the response rate was 57% (n=4). Respondents indicated that the time necessary for completing the survey was reasonable and the questions were easy to understand and general enough that

anyone working for the Human Services System would be able to answer them. Respondents also suggested that a one-page survey might produce a higher return rate.

Study Sample

A total of 900 employees at a Health Services System in California were selected to participate in this study, through stratified random sampling from a population of 3,217 workers. The use of proportional stratified random sampling allowed the sample drawn to be representative of the population. The randomization process in each job category corresponded to the proportions in the total population. A proportional stratified random sample of 900, using a 4% margin of error, was selected for the sample size. Participants were selected from five departments in this agency: 1) Community Health, 2) Employment and Temporary Assistance, 3) Adult Services, 4) Children and Family Services, and 5) Administration.

Data Collection

A total of 900 assessment tools were mailed to randomly selected employees within the five departments of the surveyed health services system. The survey instrument was accompanied by a cover letter that explained the purpose of the study, provided indications on how to state consent for participation, and gave directions on how to return the survey. An additional cover memo endorsed by the Administrative Support Officer Human Services System, emphasized the assessment's anonymity and confidentiality.

The surveys were coded in order to track response rates and maintain anonymity of the participants. Once an assessment tool was received, it was immediately separated from the envelope in which it was mailed. The envelope contained an identification number for tracking department, job category, and number of surveys returned.

Data Analysis

Continuous data were analyzed through a t-test for independent samples. Nominal data were analyzed using the Pearson chi square distribution and Yates correlation factor. The Statistical Package for the Social Sciences

(SPSS) was used to conduct the analysis. Open-ended answers were analyzed through a systematic qualitative inspection of responses.

Results

Three hundred and sixty usable surveys were returned for an overall response rate of 40%

with more administrators (55%) than staff (36%) returning the surveys. An additional 9.6% (n = 87) of returned instruments were not included in the study due to a variety of reasons (e.g., returned after the deadline). Table 1 shows the demographic characteristics of the sample population which had a mean age of 44 years.

Table 1
Sample Demographic Characteristics

Variable	Number	Percentage
Ethnicity		
Caucasian	139	38.6
Hispanic/Latino	134	37.2
Asian-Americans	39	10.8
African Americans	13	3.6
Other	11	3.1
No response	24	6.7
Gender		
Male	83	30.2
Female	187	68.0
No response	5	1.8
Education		
High School/GED	77	21.4
Associate degree	92	25.6
Bachelor's degree	118	32.8
Masters's degree	56	15.6
Ph.D./MD	5	1.4
No response	12	3.3

Results from this study indicate that administrators and staff realize the need to interact in culturally appropriate manners with members of diverse communities. The majority of staff and administrative respondents strongly disagreed with the statement "People do not have to deal with issues of cultural diversity and the need to learn about other cultures." The survey found a significant difference between staff and administrators in regard to their participation in cultural awareness activities. Administrators reported a higher level of participation in cultural awareness activities in the six months prior to the survey compared to staff. Similarly, administrators were more likely

(64%) than staff (59%) to report having utilized cultural consultants to help them work effectively with diverse populations (p = 37.708, df = 15).

This study found that 21% of administrators and 11% of staff perceived consumers' inability to locate a staff with whom they can communicate in their native language as an important barrier to health services utilization (p = 28.893, df = 15). Not surprisingly the system utilizes a number of in-house translators to deliver culturally-appropriate health care services. While the health care system depends heavily on interpreters to reach their target population,

significant differences were found among administrators and staff in regard to the number of interpreters on their staff. Over a third (34%) of administrators reported high satisfaction with the number of in-house interpreters available at work compared to 25% staff members.

There were significant differences between staff and administrators in their perception of culturally-related barriers that limit clients' access to health services. In regard to transportation, 31.2% of administrators reported transportation to be a major barrier, as compared to 30.9% of staff, who saw transportation as less of a barrier.

There were significant differences between staff and administrators in their perceived training needs. Administrators were more likely to perceive a need for training on cultural awareness and cultural sensitivity, as compared to staff. Similarly, administrators (82%) were more likely than staff (65%) to correctly indicate that their system's policy required cultural specific training ($p = 9.431$, $df = 9$). In response to a question dealing with their perceived training needs survey respondents, regardless of employment classification, indicated that the major educational needs of this sample were related to 1) cultural factors that affect consumers' access to services, 2) ethnic and cultural beliefs, traditions, and customs, 3) training for interpreters, and 4) cross-cultural communication.

Discussion

Researchers have placed a high importance on the need for organizations to self-evaluate their commitment to the delivery of effective and culturally-appropriate services. Part of that evaluation ought to be the assessment of the training needs of their employees in regards to cultural competence and cultural sensitivity.

When culture is ignored, barriers to services emerge. Culturally-biased diagnostic and assessment procedures in the recruitment, selection, and hiring process increase the chance of employing professionals who may be well-intentioned but who do not know how to work with culturally diverse populations. The negative

impact of such a situation is compounded by the fact that the number of culturally-competent administrators and staff trained to work specifically with diverse populations has not kept pace with the growth rates of multicultural groups.

The National Maternal and Child Health Center on Cultural Competency (1999) indicated that culturally competent primary public health agencies are necessary to respond to current and projected demographic changes in the United States. Culturally competent public health agencies can eliminate long-standing disparities in health status of people of diverse racial, ethnic, and cultural backgrounds; improve the quality of services and health outcomes; meet legislative, regulatory, and accreditation mandates; gain a competitive edge in the market place; and decrease the likelihood of liability/malpractice claims (Goode & Cohen, 1999).

This study found that administrators reported participating in activities related to cultural awareness twice as often as staff. While this commitment to cultural competence is commendable, it is at the same time disturbing that the people most likely to come in contact with diverse populations are less trained. This finding hold true even if staff are more likely to be members of the same ethnic/racial group as the target population as no person can be an expert regarding the rich diversity even within ethnic groups.

The findings also indicate that a greater proportion of administrators than staff perceived that contract or in-house translators were available. From a management perspective they have hired an adequate number of interpreters to deliver linguistically appropriate services. Again, this disconnect with front line personnel perception raises questions about the adequacy of the services being delivered. It should be noted that both, administrators and staff, reported that consumers did not have access to direct service employees with whom they could communicate in their native language.

Regarding perceived training needs, administrators were more likely than staff to indicate that training regarding cultural awareness and competence was needed. The findings of this study reflect the need for additional training in specific topic areas such as cross-cultural communication, ways to actively involve clients in their prevention and treatment process, and health-related beliefs across cultures.

The delivery of culturally-sensitive health services to multi-ethnic populations continues to be a struggle for most public health agencies working with diverse communities. Local health service agencies must respond to the needs for cultural training among their employees. The presence of a well-documented institutional

needs assessment may ultimately result in providing more effective services to the general population and improving morale and productivity among employees. This study supports the importance of a continuous assessment of the educational needs of public health agencies' employees regarding cultural competence. These findings may be used to revise and enhance the current human services system's training curriculum in order to improve service delivery to multicultural communities. In this regard health educators can play a key role in the development and implementation on those programs not only taking the lead in their development and implementation, but also in serving as role models in each and every program they implement.

References

- Arizona Department of Health Services. (1995). Cultural competence needs assessment. Phoenix: Arizona Department of Health Services, Center for Minority Health.
- Bell, P., & Evans, J. (1981). *Counseling the Black client*. Center City, MN: Hazelden Education Materials.
- Borkan, J., & Neher, J. (1991). A developmental model of ethno sensitivity in family practice training. *Family Medicine*, 23, 212-217.
- Campinha-Bacote, J. (1994). Cultural competence in psychiatric mental health nursing: A conceptual model. *Nursing Clinics of North America*, 29(1), 1-8.
- Cross, T. L., Brown, B. J., Dennis, K. W., & Isaac, M. R. (1998). *Towards a culturally competent system of care. Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, D.C.: Child and Adolescent Center, Center for Child Health and Mental Health Policy.
- Fortier, J. P., & Taylor, Y. S. (1999). *Assuring cultural competence in health care: Recommendations for national standards and an outcomes-focused research agenda*. Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health.
- Goode, T., & Cohen, E. (1999). *Rationale for cultural competence in primary health care (National Center for Cultural Competence Policy Brief 1)* (p. 5). Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health.
- Goode, T., Sockalingam, S., Brown, M., & Jones, W. (2000, Winter). *Infusing principles, content and themes related to cultural and linguistic competence into meetings and conferences (National Center for Cultural Competence Planning Guide)* (p. 13). Washington, DC: U.S. Department of Health and Human Services Office of Minority Health.
- Hernandez, M., & Isaacs, M. (1998). *Promoting cultural competence in children's mental health services*. Baltimore, MD: Paul H. Brookes Publishing Co., Inc.
- Jackson-Carroll, L. N., Graham, E., & Jackson, J. C. (1996). *Beyond medical interpretation: The role of interpreter cultural mediators in building bridges between ethnic communities and health institutions*. Seattle, WA: Community House Calls, Harborview Medical Center.
- Luquis, R., & Pérez, M. A. (2005, June). Health educators and cultural competence: Implications for the profession. *American Journal of Health Studies*, 20(3).

- National Alliance for Hispanic Health. (2000). Quality health services for Hispanics: The cultural competence component (DHHS Publication No. 99-21). Washington, DC: U.S. Government Printing Office.
- National Maternal and Child Health Center on Cultural Competency. (1999). Rationale for cultural competence in primary health care. Washington, DC: Health Resources and Services Administration, Maternal Child Health Bureau.
- U.S. Census Bureau. (2002). Projections of the Resident Population by Race, Hispanic Origin, and Nativity: Middle Series, 2016 to 2020. Washington, DC: U.S. Department of Commerce. Retrieved March 20, 2006, from <http://www.census.gov/population/www/projections/natproj.html>
- Settles, S. (2003). Managed care moves to the head of CLAS: Implementing culturally and linguistically appropriate services. *Closing the Gap*, August, 2003, 15.
- Yee, B., Mokuau, N., Sehwan, K. (1999). Developing cultural competence in Asian-American and Pacific Islander communities: Opportunities in primary health care and substance abuse prevention (5th ed.) (DHHS Publication No. SMA 98-3193). Washington, DC: U.S. Department of Health and Human Services.

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