Summary Report
Cultural Competence in Primary Health Care: Perspectives, Tools and Resources

For: Capital District Health
By: Janet Rhymes and
Darren C Brown
Logical Minds Consulting
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Executive summary

The goal of this report is to provide the reader with a greater understanding of the core concepts in cultural competence in primary health care. The content of this report was obtained through a literature review and environmental scan conducted in the spring of 2005. The particular area of focus for this review is on credible, practical approaches and strategies to assist individuals, organizations and systems to move towards cultural competence, including training. There is an abundance of literature and programs available on cultural competence in health care—this is in no way meant to be an exhaustive review.

There are a variety of definitions for cultural competence[1], and a number of related terms, such as cross-cultural education, linguistic competence and cultural proficiency. Cross et al (1989) state that cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations" According to Betancourt et al (2002): "Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs."

The field itself presents a number of challenges, including the following:
- a lack of agreement on definitions and approaches;
- lack of research on impact and effectiveness;
- the confusion of race with culture; and,
- generalizing cultural characteristics in a way that leads to stereotyping.

An additional complicating factor is that cultural competence is not simply a skill set to be taught, but involves a fundamental shift in the way one perceives the world. It is more a path on which to travel, versus an end to be achieved. Lecca et al (1998: 52) describe a Cultural Competence Continuum Scale that involves moving along the following stages: cultural destructiveness; cultural incapacity; cultural blindness; cultural pre-competence; cultural competence; and cultural proficiency.

The failure to consider culture contributes to inadequate care. This includes poor health outcomes, underutilization of services, inequities, increased burdens from morbidity and mortality. Cultural competence is beneficial for the following reasons:
- makes more effective use of time with patients;
- increases disclosure of patient information;
- helps with negotiating differences;
- increases patient compliance in treatment protocols;
- positively affects clinical outcomes;
- improves communication with patients;
- decreases stress;

[1] Also known as transcultural care in some literature.

- builds trust in a relationship;
- increases patient satisfaction; and,
- meets increasingly stringent government regulations and medical accreditation requirements.

As a result, cultural competence must be integrated into public health policy, programs and services. This includes having culturally competent health care providers. Techniques for achieving cultural competence in health have been well documented, and can be clustered into nine categories, although there is little evidence on effectiveness of each technique (Brach and Fraser 2000).

1. Interpreter services.
2. Recruitment and retention.
3. Training.
4. Coordination with traditional healers.
5. Use of community health workers.
6. Culturally competent health promotion.
7. Including family and/or community members.
8. Immersion into another culture.
9. Administrative and organizational accommodations.

Training and education is a crucial component in the field of cultural competence. A variety of training programs are outlined in the literature and reviewed in this report. For example, Carillo, Green and Betancourt (1999) suggest a five-module, case-based training exploring social and cultural factors and teaching physicians questioning techniques versus learning presumed cultural characteristics.

McNaughton-Dunn (2002) emphasizes six elements for cultural competence: changing the world view of the learner; becoming familiar with core cultural issues and cultural groups with whom the learner works; becoming familiar with cultural issues related to health and illness; developing a relationship of trust with clients; and, negotiating interventions of care.

According to Duffy (2001) cultural competence training must include critical reflection and self-transformation. It should begin with an acknowledgement of racism, and then look at what cultures have in common versus differences between cultures. The overall goal should be to work towards shared power between members of equal but different cultures.

Campinha-Bacote (2001, 2003) promotes a five-component system for cultural competence in healthcare delivery, which focuses on five interdependent components: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. These are linked in that cultural desire is seen as the “volcano” that erupts to allow a person to genuinely seek cultural encounters, obtain cultural knowledge, construct culturally sensitive assessments and be humble to the process of cultural awareness.

A culturally competent community care model (CCCC) has been proposed by Kim-Goodwin, Clarke and Barton (2001), which includes the following four dimensions: caring, cultural sensitivity, cultural knowledge and cultural skills.

Research by the United States Institute of Medicine (IOM) recommends the following strategies to attempt to reduce racial and minority health disparities:

- increase the proportion of under-represented racial and ethnic minorities among health professionals;
- enhance patient-provider communication and trust;
- support the use of interpretation services;
- support the use of community health workers; and,
- integrate cross-cultural education in the training of all current and future health care providers.

In addition, the US Office of Minority Health recommends fourteen national standards for Culturally and Linguistically Appropriate Services (CLAS) to support a more consistent and comprehensive approach to cultural and linguistic competence in health care. These standards are included in the appendix of this report.

One key component for both systems and individuals to achieve cultural competence is increased self-awareness with a critical examination of beliefs, values and biases. This can be accomplished through self-assessment by health care organizations or by individual practitioners. Self-assessment is said to be an essential element of cultural competence. A number of well-developed self-assessment resources are available online and are referenced in this report.

A recent (2003) compendium of initiatives for cultural competence has been created by Rees and Ruiz, Kaiser Family Foundation. This provides a tabular summary of public, private and state initiatives to address cultural competence across the United States. It is an excellent all-round resource for searching for practical projects that have been completed, especially training, assessment, evaluation and standards.

The final section of this report summarizes useful tools, resources and information portals for fostering cultural competence. These include tools for cross cultural communication; patient's health belief assessment guides; communication interviewing questions; sample self-assessments and a list of web-based information sources on the topic.

Having considered this subject, the authors propose the following recommendations:

- Conduct an environmental scan to determine what cultural competence initiatives have been implemented and are currently underway in the Capital District.
- Take a planned, interdisciplinary and culturally diverse strategic approach.
- Targeting specific sectors, complete further research on programs and resources in other areas.
- Start by increasing awareness of the need for cultural competence.
- Increase the proportion of under-represented culturally diverse minorities among primary health care professionals.

- Learn more about the culturally diverse communities and individuals you serve. Enter their world.
- Enhance client-provider communication and trust.
- Support the use of interpretation services if requested by the communities you serve.
- Increase knowledge of traditional healers and alternative health care providers within the community served.
- Consider literacy in communicating with clients and in population health promotion.
- Support the use of community health workers.
- Integrate transformative cultural education in the training of all current and future providers and staff.

Introduction

This report provides a brief overview of the concept of cultural competence in primary health care, with an emphasis on useful tools and resources. It is made up of three main sections:
I. An overview of background information and key concepts
II. Common strategies for approaching cultural competence
III. Useful tools and resources

The content for this report was obtained through a literature review and environmental scan conducted by the authors in the spring of 2005. Additional literature and scan information was kindly provided by Sharon Davis-Murdoch, Senior Policy Analyst, Nova Scotia Department of Health. Our thanks and gratitude is extended to her for the loan of those materials.

There is an abundance of cultural competence literature and program information available. ***It is important to note that this report represents a small initiative, limited in funding and scope, and that this is in no way meant to be an exhaustive overview of the cultural competence field.*** It is a brief scan and, as a result, exact text from key references is included in some cases.

The goal of this report is to provide the reader with a greater understanding of the core concepts, as well as useful strategies, tools and approaches for assisting primary health care and primary care providers, agencies and systems work towards greater cultural competence. It is accompanied by a MS Power Point presentation summarizing key ideas and findings and a *Diversity and Social Inclusion in Primary Health Care* one-day training workshop.

> *"Adding wings to caterpillars does not create butterflies--it creates awkward and dysfunctional caterpillars. Butterflies are created through transformation..."*
> *Stephanie Marshal*

I. Cultural competence: an overview

1. Useful definitions: culture and cultural competence

Summary: There are a variety of definitions for cultural competence, as well as related terms

This discussion starts with key definitions of culture and cultural competence. Cultural competence is also noted in some literature and/or by some practitioners as transcultural care.

Culture is defined in several ways, including "the integrated patterns of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups" (Cross et al, 1989).

According to McNaughton-Dunn (2002: 105 - 106), *culture* emerges in the transactions between humans and their physical and social environment. Humans create culture as a way to name, understand and manage the world around them As a result culture is dynamic, constantly changing, evolving and being created.

Cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations"
(Cross et al., 1989).

Cultural competence is defined simply as the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group. (DHHS, HRSA[2]).

"*Cultural competence* comprises behaviors, attitudes, and policies that can come together on a continuum: that will ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups. Cultural competency is a goal that a system, agency, program or individual continually aspires to achieve" (DHHS, HRSA[3]).

"*Cultural competence* in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs"(Betancourt et al., 2002).

"*Cultural competence* is the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and relevance, and treatment efficacy. But perhaps the most significant aspect of this concept is the

[2] U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA).
[3] As above.

inclusion and integration of the three areas that are usually considered separately when they are considered at all" (Lavizzo-Mourey and Mackenzie, 1996).

Cultural competence is most often used with respect to racial and ethnic minority groups. Barriers from linguistic ability, either non-first language speakers or low literacy levels, constitute an important component of cultural competence. Cultural competence can also incorporate other marginalized groups such as women, the elderly, gays and lesbians, people with disabilities and religious minorities (Brach and Fraser 2000: 183).

Other related definitions

"*Cross-cultural education* can be divided into three conceptual approaches focusing on attitudes (cultural sensitivity/ awareness approach), knowledge (multicultural/ categorical approach), and skills (cross-cultural approach), and has been taught using a variety of interactive and experiential methodologies" (IOM, 2002[4]).

Cultural proficiency is "when providers and systems seek to do more than provide unbiased care as they value the positive role culture can play in a person's health and well-being" (National Alliance for Hispanic Health cited by Kaiser Family Foundation 2003).

Linguistic competence is the capacity of an organization and its personnel to effectively communicate with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals with disabilities. This may include, but is not limited to, the use of: bilingual/bicultural staff; cultural brokers; multilingual telecommunication systems; ethnic media in languages other than English (e.g., television, radio, newspapers, periodicals); print materials in easy to read, low literacy, picture and symbol formats; and materials in alternative formats (e.g., audiotape, Braille, enlarged print) (Goode and Jones, 2002 cited by Kaiser Family Foundation 2003).

Culturally and linguistically appropriate services (CLAS) are "health care services that are respectful of and responsive to cultural and linguistic needs" (DHHS, OMH[5], National Standards for CLAS, 2001).

Cultural sensitivity is "the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic or cultural heritage" (DHHS, OMH, National Standards for CLAS, 2001).

[4] US Institute of Medicine
[5] Office of Minority Health

2. Key challenges and implications

Challenges in the field include a lack of agreement on definitions and approaches, lack of research on effectiveness, the confusion of race with culture and generalizing cultural characteristics leading to stereotyping. As well, cultural competence is not simply a skill set to be taught, but involves a fundamental shift in the way one perceives the world. It is more of a path on which to travel, versus an end to be achieved.

The field of *cultural competence* presents several challenges (Rees and Ruiz, 2003: 5) including:

- lack of agreement on the terms, definitions, and core approaches;
- limited research on impact and effectiveness; and,
- a misperception that the activities are focused exclusively on people of color, rather than also on diverse population groups that, for example, arise from religious affiliation, class, or sexual orientation.

"What is still lacking is evaluation, namely, measures not merely of changes in knowledge and attitudes but also of changes in outcomes. We do not know yet what really works" (Geiger, 2001: 1700).

It is impossible to generalize cultural characteristics to all members of a cultural group. This would be stereotyping. Not all people within a group have the same values, beliefs and behaviours. There can be shared values, but these can be adaptable, flexible, consistent and inconsistent at the same time (McNaughton Dunn 2002, 106).

Kagawa-Singer, M and S Kassim-Lakha (2003) point out that there is a great variety of national and ethnic groups in each national group, each with its own culture or subculture. There are also varying levels of acculturation and assimilation within individuals of cultural groups. "Cultures are also not homogeneous or monolithic. Varying levels of acculturation, assimilation, age, education, income, family structure, gender, wealth, foreign versus U.S.-born status, and refugee or immigrant status all modify the degree to which one's cultural group membership may influence health practices and health status."

Here is a simple example of what is problematic in traditional cross-cultural education.

> A case presentation routinely includes a racial designation, such as "a 65-year-old Chinese male presents with chest pain." What information does "Chinese" convey? This man could have been born in Hong Kong, be a college professor who speaks five languages including English, and lives six months of the year in the United States and six months in Hong Kong. This man could also be a monolingual Chinese gentleman, born in the United States, unmarried, and living alone in Chinatown in New York, with little education and very poor. Lack of accountability for these differences perpetuates stereotypical evaluations and diverts the clinician from accurately assessing the strengths of and potential conflicts with individual patients and their families."

They recommend a new paradigm supporting the use of cross-culturally competent practitioners with outcomes to indicate that patients and families are able to promote, maintain, and/or regain mutually desired and obtainable levels of health within the realities of their life circumstances. They stress the important idea that cultural competence is not about negotiation to "educate" the patient into the biomedical model. "This negates the integrity of culture and is problematic in a multicultural society."

Cultural competence is not something that can be taught in traditional ways. It is not:

- a technical skill that one can master.
- a problem solving skill to develop.
- a communication technique to refine.

"Cultural competence, in fact, requires a fundamental change in the way people think about, understand and interact with the world around them" (McNaughton Dunn 2002, 107).

Like the definition of culture itself, cultural competence is dynamic, shared, learned and integrated. It is a continuous, dynamic process, not simply an end to be reached.

In addition, cultural competence must be approached from all levels, across a continuum of services, including individuals, agencies, organizations and systems.

Lecca *et al* (1998: 52) describes a Cultural Competence Continuum Scale that involves the following stages:

- Cultural destructiveness.
- Cultural incapacity.
- Cultural blindness.
- Cultural pre-competence.
- Cultural competence.
- Cultural proficiency.

Cultural destructiveness
Most negative end of the continuum, represented by attitudes, polices and practices that are destructive to cultures and individuals. Forcibly removing native children from their families and communities and placing them in residential schools is an example of systemic cultural destructiveness.

Cultural incapacity
This occurs when a system or agency does not intentionally attempt to destroy a culture, but it lacks the capacity to help minority clients or communities. The agency or system believes it is in a morally superior position—that its own culture and its way of "doing" is best.

Cultural blindness
This is the belief that culture actually makes no difference and that all cultures are essentially the same. A system or agency that is culturally blind believes that the

"helpful" approaches used by the dominant culture are universally acceptable. Assimilation is encouraged.

Cultural pre-competence
This is the first step towards the more positive end of the continuum. The agency realizes its weaknesses in serving minorities and tries to improve. It tries to reach out to people of colour within the area it serves, hires minority staff, provides an initial worker training in cultural sensitivity, and wants to deliver quality services. However, at this point, the agency feels it has done enough and does not try to do more. If efforts fail, the agency does not try again.

Cultural competence
The agency or system accepts and respects differences and carries out continuous self-assessment of staff and policies regarding culture. It pays attention to the dynamics of difference and continuously expands its cultural knowledge and resources and always adapts service models to meet minority needs. The agency or system seeks committed minority staff and provides support to staff members to help them work effectively in cross-cultural situations. It seeks advice and consults with the minority community.

Cultural proficiency
The agency or system holds other cultures in high esteem. Culturally competent practice is enhanced by research, by therapeutic approaches based on culture and by publishing and disseminating the results. The agency hires staff specializing in culturally competent practice. It respects different cultures and works with community and religious leaders even if not in agreement with their practices. The agency builds cultural knowledge, uses self-assessment procedures and understands cultural dynamics. Polices are flexible, and culturally impartial—all staff are part of this process.

(All adapted from Lecca, 1998)

3. How does culture affect health?
The failure to consider culture contributes to inadequate care. This includes poor health outcomes, underutilization of services, inequities, increased burdens from morbidity and mortality. As a result, cultural competence must be integrated into public health policy, programs and services. This includes having culturally competent health care providers.

Cultural bias and a failure to understand how culture affects health and illness and can contribute to inadequate care (Smith, 2001; Walker and Jaranson 1999).

How? At best, each person is treated the same. At worst, providers' cultural blinders prevent them from accurately identifying problems and fundamental qualities of clients' "dis-eases" are never rectified nor treated.

Cultural insensitivity can also lead to interventions that deny the integrity and value of clients. As a result, patients underutilize health services, providers believe that patients are non-compliant, and both end up frustrated or angry (Fadiman, 1997).

Ultimately, inequities exist in the health status of clients who are poor, or of diverse cultures, ethnic backgrounds, or races. Unless providers become more culturally competent, these inequities will only worsen as demographic trends towards diversity continue (McNaughton Dunn 2003).

According to Geiger (2001), worldwide, racial and ethnic minorities are afflicted with increased burdens from morbidity and mortality. Some of these poor outcomes are due to poverty and related environmental factors—social, physical, biological, economic and political—as well as lack of access to health care. However, a significant portion may be a result of "racial and ethnic disparities in the quality of medical care, specifically, by differences in the diagnostic work-up and treatment of minority patients already in the health care system" (Geiger 2001: 1699).

Some examples?

- In the United States, African Americans, people of Hispanic origin and American Indians are much less likely to receive coronary artery angioplasty or bypass surgery, advanced cancer treatment, renal transplantation or surgery for lung cancer compared with white patients matched for insurance status, income, education, and severity of disease, co-morbidity, age, hospital type and other possible confounders.
- These differences were also found for basic elements of clinical care, such as the adequacy of physical examinations, history-taking and laboratory tests—even the adequacy of medication for pain—across the whole spectrum of disease."

Cultural competence[6] is beneficial because it:

- makes more effective use of time with patients.
- increases disclosure of patient information.
- helps with negotiating differences.
- increases patient compliance in treatment protocols.
- positively affects clinical outcomes.
- improves communication with patients.
- decreases stress.
- builds trust in a relationship.
- increases patient satisfaction.
- meets increasingly stringent government regulations and medical accreditation requirements.

According to the US National Centre for Cultural Competence (NSCC), there are six reasons why cultural competence needs to be incorporated in to public policy.

1. To respond to current demographic projections.

[6] Adapted from www.med.umich.edu/multicultural/ccp/index.htm.

2. To eliminate long-standing disparities in the health status of diverse racial, ethnic and cultural backgrounds. Disparities are in incidence of illness and death among minority communities versus population as a whole.
3. To improve the quality of services and health outcomes.
   "The delivery of high quality primary health care that is accessible, effective and cost efficient requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live. Culturally competent primary health services facilitate clinical encounters with more favourable outcomes, enhance the potential for a more rewarding interpersonal experience and increase the satisfaction of the individual receiving the services (2 of 5).
4. To meet legislative, regulatory and accreditation mandates.
5. To gain a competitive edge in the marketplace.
6. To decrease the likelihood of malpractice/liability claims.

In addition, research shows that increasingly, clients are using health care systems other than biomedicine, such as complementary and alternative medicine, which necessitates the need for improved cultural competence and negotiation with patients regarding treatments (Tervalon 2003: 571).

The Canada Health Act provides the framework for health care in Canada. One of five principles is accessibility, referring mainly to financial barriers. However, Health Canada reports acknowledge that other barriers presented by language and culture may also hinder communication with providers and systems, thus impeding access (Health Canada 2000).

The US Institute of Medicine (IOM) of the National Academy of Sciences and Physicians for Human Rights appointed panels to review the evidence regarding cultural competence in health care and make recommendations for change. A joint working group in the UK and US has looked into the role of institutional racism in creating disparities for care. Cultural competence is also a growing area of interest at the graduate and undergraduate level of training as well as for health provider continuing education. It is increasingly the focus of scholarly research.

II. Working towards cultural competence

As previously mentioned, cultural competence must be approached across a continuum of services and at a number of levels. These include individual care providers as well as agencies, and systems. In addition, it is clear that although there is substantial evidence to suggest that cultural competence is critical, there is little evidence regarding which approaches and techniques are effective and how and when to implement them properly (Brach and Fraser, 2000: 181). It is important to keep this in mind when considering cultural competence in primary health care.

This section of the report outlines some techniques and concepts most frequently used to address cultural competence at both the individual (clinical), systems and organizational levels.

1. Clusters of approaches for achieving cultural competence
Techniques for achieving cultural competence in health have been well documented, and can be clustered into nine categories, although there is little evidence on effectiveness of each technique.

Brach and Fraser (2000) describe the techniques for achieving cultural competence in health care, clustering them into nine categories. These categories are further outlined below. Individual projects or models within each cluster are also included.

1. Interpreter services.
2. Recruitment and retention.
3. Training.
4. Coordination with traditional healers.
5. Use of community health workers.
6. Culturally competent health promotion.
7. Including family and./or community members.
8. Immersion into another culture.
9. Administrative and organizational accommodations.

1. Interpreter services

This category includes provider foreign language or sign language interpreter services. Health care services offer on-site professional interpreters, ad-hoc interpreters (staff taken from other duties to interpret, friend and family), and remote interpreters (working using earphone and microphones).

2. Recruitment and retention

There is significant literature that supports the hiring of minority staff as a way to improve communication and create a welcoming environment and structure health systems to meet minority needs. Common techniques to accomplish minority recruitment include:

- Minority residency and fellowship programs.
- Hiring minority search firms.

- Adapting personnel policy to create a welcoming and comfortable workplace for minorities.
- Mentoring of minority workers by senior executives.
- Subcontracting with minority care providers.
- Tying executive compensation to matching hiring to community needs.
- Expanding on affirmative action programs.
- Establishing principles for respectful treatment.
- Reviewing HR policies, practices and compensation.
- Tracking staff satisfaction by racial and ethnic group.

For example
American Medical Association (AMA), Doctors Back to School Program
Doctors Back to School is a program that aims to raise awareness of the need for more minority physicians and to encourage children from underrepresented minority groups to look at medicine as a career option. Through Doctors Back to School, physicians and medical students across the United States visit schools and community organizations to help young minority children realize they can follow the same path.

See: http://www.ama-assn.org/ama/pub/category/7131.html

Note: Many cultural competence initiatives target literacy for improved communication and health promotion, not simply language competence.

3. Training
Training for cultural competence can be within health care provider training programs, new staff orientations and as continuing education modules. It can be a one-time event or an ongoing activity. There are a wide variety of training programs and approaches that have been reviewed in the literature. Training is discussed in much greater detail later in this report.

4. Coordinating with traditional healers
Some cultural minority communities use traditional healers at the same time as conventional health care providers. Providers need to coordinate with them to ensure continuity and avoid complications. This also increases the chance that the patient will concur with and adhere to treatment.

5. Use of community health workers
Community health workers, known and respected within cultural minority communities can serve as guides or liaisons between "the system" and patients.

6. Culturally competent health promotion
This can range from clinicians use of screening tools and brief interviews to larger public information campaigns. In all cases, culture-specific attitudes and values are incorporated into messages and materials.

7. Including family and community members

Some minority groups feel that family members should be involved in health care. Involving families and even community leaders can be crucial in some communities to consent and adhere to treatment.

8. Immersion into another culture

Cultural immersion is an excellent way to obtain the transformative education needed to become more culturally competent. Immersion has been shown to help providers get over their ethnocentrism, increase cultural awareness and integrate cultural beliefs into practice (St. Clair and McKenry 1999, cited by Brach and Fraser, 2000).

Some nursing and physician training programs, for example, require the student to complete a work or learning term in an international setting or in a hospital that services culturally diverse minority communities.

9. Administrative and organizational accommodations

These strategies include attention to clinic location, hours, and physical environments, written materials and so on. Systems can ensure their minority patients are granted equal access to high-quality services and providers. It is important here to keep in mind that competence extends beyond providers to all staff—appointment desk, help lines, and in memberships and written materials.

For example

Cultural Competence: It All Starts at the Front Desk

This initiative of the Centre for Cultural Competence, Georgetown University, raises awareness and offers suggestions for policies and procedures, workforce development and quality improvements within the front offices/waiting rooms, reception areas of health care agencies and organizations. These areas are usually the first point for ongoing contact between clients and the care system and ensuring that they are culturally competent is important.

For more information, see:
http://gucchd.georgetown.edu/nccc/documents/FrontDeskArticle.pdf

2. Training for clinical cultural competence

Training and education is a crucial component in the field of cultural competence, hence this section is devoted entirely to training. According to Dunn (2002) providers want to do the right thing for their cultural minority clients, but often fall back to "politeness and kindness". More is required, including the development of education and training programs. These are essential and can help providers be more capable when engaging with diverse clients. According to Dunn (2002), the goal must be to change the way people think about, understand and interact with the world around them.

The literature outlines many different but related training programs, usually for nurses or physicians. Some examples of training programs are included in the section that follows.

a) Three-step process

Betancourt, Green and Carillo 2002

Betancourt, Green and Carillo (2002) see provider cross-cultural training as a three-step process:

1. Make providers aware of the impact of social and cultural factors on health beliefs and behaviours.
2. Equip them with the tools and skills to manage these factors appropriately through training and education.
3. Empower their patients to be more of an active partner in the medical encounter.

For example

Why the Difference, Kaiser Family Foundation

One of the barriers to advancing cultural competence is that individuals and systems do not recognize it as a priority or area of concern. A recent Kaiser Family Foundation national initiative aims to raise physician awareness about racial and ethnic disparities in medical care, beginning with cardiac care. It provides physicians with a speaker's kit, Power Point presentation, fact sheets and other resources to assist them in raising awareness of the importance of cultural competence among physicians.

See: http://www.kff.org/whythedifference/index.htm

In addition, Betancourt, Green and Carillo (2002) recommend improvement in the quality of care, including culturally and linguistically appropriate patient survey methods, process and outcome methods as well as programs to educate patients how to navigate the health care system and become active participants in their care.

b) Five-Module Training

Carillo, Green and Betancourt 1999

A five-module, case-based training exploring social and cultural factors and teaching physicians questioning techniques versus learning presumed cultural characteristics

The authors present the ideology and structure of a patient-based cross-cultural curriculum that has been developed and implemented. It is a melding of medical interviewing techniques with the socio-cultural and ethnographic tools of medical anthropology. It is comprised of five modules that include skills and concepts that build on one another over four, two-hour sessions. These modules are outlined below.

The questions used to guide these interviews for all modules can be found in the Tools and Resources section, page 35 (see: communication interviewing questions)

Module 1: Basic Concepts

Introduction to the definition of culture

- shared system of beliefs, values and learned patterns of behaviour; shaped by other factors such as education, gender etc.

In interactive small groups, participants reflect on their own cultures and how these influence their personal perspectives on illness and health care. They explore:

- the way "medical culture" has become integrated into their cultural outlook.
- disease as a patho-physiological process versus a patient-centred, more subjective concept of illness.

They examine vignettes and video interviews to gain an appreciation for the diverse conceptualizations of illness that patients may present to physicians. Essential attitudes for a successful cross-cultural encounter are identified as empathy, curiosity, and respect

Module 2: Core Cultural Issues
According to the authors, learning specific generalities about each culture is impractical and unrealistic. There can be significant variations within groups and across cultures. Instead, the participants explore various types of problems that are likely to arise in a cross-cultural encounter and learn to identify and deal with them as they arise.

They provide a short vignette to initiate dialogue on this topic.

Module 3: Understanding the Meaning of the Illness
This module starts with the premise that the patient enters the office with his/her own beliefs, concerns and expectations—the patients' explanatory model (it includes what the patient thinks about the causes, proper treatments and how the illness affects their life). These features of the patient model can be culturally determined, but there are also other influences, such as gender or low socioeconomic status etc.

Participants are encouraged to first use a set of interview questions (first developed by Kleinman 1978) to determine these patient-based factors. These questions can be adapted for uses other than illness. The module includes time for participants to practice these questioning techniques using trained actors as pseudo patients.

Module 4: Determining the social context of the patient

It is much more important to know what sort of a patient has a disease, than what sort of disease a patient has.

William Osler

In this module, physicians learn practical techniques to explore and manage the social factors most relevant to the medical encounter. Through asking a series of questions, they ascertain the social context of the patient–SES status, migration history, social networks, literacy and other factors.

There are four avenues of exploration:

1. Control over environment (including financial resources, and education).
2. Changes in environment (i.e. migration).
3. Literacy and language.

4. Social stressors and support systems.

This line of questioning focuses on asking the patient, “How has this illness affected your life” and “What worries you most?”

Patients and practitioners are encouraged to discuss strategies and resources to deal with these issues.

Module 5: Negotiating Across Cultures

Social and cultural factors determine differences in expectations, agendas, concerns, meanings and values between patients and physicians. This module aims to develop cross- cultural negotiation—reaching mutually acceptable agreement between provider and patient. These six phases are considered:

- Relationship building.
- Agenda setting.
- Assessment.
- Problem clarification.
- Management.
- Closure.

Negotiation involves acknowledgement of differences in beliefs between the patient model and the provider model. If the patient doesn’t buy in, compromise may be needed. The negotiation must be framed in a way that reflects the explanatory model of the patient.

c) American Medical Student Association (AMSA) PRIME curriculum

In an effort to foster cultural competency in medical schools, the American Medical Student Association and the Promoting Reinforcing and Improving Medical Education (PRIME) project has developed a one-year pilot curriculum for addressing issues of diversity in medicine.

Core competencies within this curriculum include:

- Cultural models of health, disease and illness.
- Cultural/traditional care practices.
- Negotiating cultural conflicts.
- Effective communication and interviewing.
- Using interpreters.

Some have adapted this curriculum for surrounding community and institutions.

d) Six elements for cultural competence

McNaughton-Dunn 2002

Emphasizes six elements for cultural competence: change your world view, become familiar with core cultural issues, cultural groups with whom you work and cultural issues related to health and illness, develop a relationship of trust and negotiate interventions of care

According to McNaughton-Dunn (2002: 107), becoming culturally competent means:

a) learning about the culture of the other.
b) being able to assess from the culture of the other.
c) sharing in the culture of the other.
d) the ability to communicate between and among cultures.
e) the ability to demonstrate skill outside one's culture of origin.

To achieve cultural competence a person must have these attitudes:

- empathy for others, an openness to feeling what the other feels;
- curiosity, a willingness to ask questions in order to better understand;
- a basic respect for self and others, an acknowledgement of the intrinsic value of all humans.

Dunn lists six elements in the process for developing cultural competence. These are not necessarily a sequence—there is no specific recommended order.

1. Work on changing one's world view.
2. Become familiar with core cultural issues.
3. Become knowledgeable about cultural groups with whom we work.
4. Become familiar with core cultural issues related to health and illness.
5. Develop a relationship of trust.
6. Negotiate for mutually acceptable and understandable interventions of care.

1. Changing your world view

For someone from dominant culture (i.e. European-based Western tradition), a change in world view requires two important actions: The first is to acknowledge that among this culture's deeply ingrained values are those that perpetuate separation and discrimination. The provider must acknowledge that he/she lives in a racist society. The second is to reject racism and the institutions that support it. The goal is that providers embrace the belief that it is these differences that bring a unique, legitimate perspective to human discourse.

Cultural competence training should also look for ways for people to spend time with other cultural groups—attending cultural events, travel to other countries and so on. Include time to reflect on the experience to integrate it into one's world view.

2. Become familiar with core cultural issues

It is not possible to know everything there is to know about one culture. It is possible to explore certain issues with the specific clients served. Then differences and similarities become more apparent. Issues include:

- Innate human characteristics or physical and biological variations (there is actually very little genetic variation within entire human race) (Venter et al 2001).
- Concepts of time, space and physical contact (i.e. What physical distance is comfortable? What about touching?).
- Style and patterns of communication (i.e. Implicit or explicit)
- Physical and social activities that are expected or require of different members of the group.

- Nature of self-identity or self-orientation (i.e. Individualistic or collective orientation. Is the person placed within context of the past, present, future in some social process?)
- Relationships with others, including gender, age, class (i.e. Perhaps in some patriarchal cultures the grandfather is expected to make decisions for family members).
- System of social organization (i.e. Family structure, religion, occupations).
- Relationships with nature, beliefs about qualities of natural world (i.e. Animism) and sense of environmental control and responsibility (nature to be cared for and protected).

3. Become knowledgeable about the cultural group represented by clients
Increase provider knowledge regarding the cultures they work with. This relates to the cultural variances cited above but moves beyond that to finding out how people in culturally specific groups respond to those variances. Providers must interactively participate with, or "encounter," the clients' culture. This is challenging. Start by reading about cultural groups, learn their history, health beliefs and practices and take cultural learning trips.

Of equal importance is that the individual client may not match the "textbook" case. Providers must learn about each client's unique history. This prevents stereotyping and the failure to assess individual needs. Include questioning and discussion on client's social context and socioeconomic status. The provider must ask questions, observe and ask respectfully for explanations to help build understanding.

4. Become familiar with core cultural issues related to health and illness
Cultures show particular approaches to defining, naming and giving meaning to disease or illness. Causes, treatments, responses, are all areas where there are differences among cultures.

Cultural competence means communicating in a way that allows the client to explain what an illness means to them. Two-sided sharing is needed. Providers have to get to the reality of the client and introduce the client to their culture as it relates to health care. The provider must also explain to the client their perception of the situation. The provider must clarify the client's perspective and make his or her own explanation clearer and more relevant as a result. In this fashion a common understanding is built.

The Kleinman, Eisenberg and Good (1978) questions are recommended here (see Tools and Resources, page 34, Patient's Health Beliefs Assessment Guide)

5. Develop a relationship of trust/create a welcome atmosphere in the health care setting
There needs to be a relationship of trust for clients to reveal ideas that might not be the same as those of the provider. Use hypothetical statements and requests for information

expressed with care. Get the information needed, provide an empathetic nod and verbal assurance and keep building knowledge and awareness of the client and their culture.

6. Negotiate for mutually acceptable and understandable interventions of care
Based on the assessments, the provider must negotiate with clients to plan the care. The provider may need to work with a cultural interpreter—someone who can explain the client's interpretation and provide linguistic interpretation. This doesn't mean getting clients to understand what the provider wants. This is a negotiation process. It assumes providers will be willing to adapt their clinical intervention to fit the framework of the client.

This negotiation process raises questions of professional responsibility. As a rule of thumb, Dunn suggests the following series of questions:

- What effect will client's preferred intervention have?
- Will it be helpful? Is it innocuous? Is it neither harmful nor helpful?
- Will it harm the individual?

If it is neither helpful nor harmful and the client thinks it will work, encourage it. If it is harmful, negotiate further. The final decision still may not be what the provider would have chosen.

The goal in client-provider interaction is not to increase compliance, but to increase the clients' control of the situation and to include the client fully in the decision-making process around their illness. In sharing values and beliefs, a mutual change takes place. A new culture is created which keeps the integrity of old culture but brings participants to a place of common understanding.

The goal of culturally competent care is to engage clients and providers as full participants in creating a new culture within the context of their health and illness experience. This will be a new culture of shared meaning, values and expected behaviours—dynamic, integrated and ultimately, healthful (Dunn: 110).

e) Important critique of cultural competence training/education
Duffy 2001

Remember that cultural competence training must move to critical reflection and self-transformation. It begins with acknowledgement of racism, looks at what cultures have in common versus differences between cultures and works towards shared power between members of equal but different cultures.

A recent article by Duffy (2001) provides an important critique of cultural education. Duffy states: "Approaches to cultural education embedded in traditional anthropology, are obsolete and fail to acknowledge the global environment that impacts even the most remote and isolated cultures." Programs tend to focus on identifying characteristics of specific cultures, but this focus on multiculturalism is said to actually increase the

distance between cultures. It focuses on the superficial and doesn't address underlying social conditions and issues of cultural acceptance and integration.

Specifically, many programs focus on defining "the self" from "the other", with a focus on the differences between cultures. They also then move to stereotyping by "homogenizing" a group of people based on teaching generalizations about their cultural characteristics. This approach is not based in theory (Brink 1994, cited by Black 2001).

In addition, many programs do not allow time for *critical reflection*—the work of self-transformation. It is important to clarify this concept. Often, programs encourage students to be aware of their beliefs, attitudes and feelings, and the impact of this on those they care for. The goal is adapt care to the culture of the client. But, the power and perspective remain in the hands of the dominant culture. This approach has been termed *thoughtful action with reflection* (Mezirow et al 1990, cited by Duffy 2001). Duffy feels programs must go beyond this to achieve *critical reflection*—a much deeper process that raises doubts on existing assumptions and uses a critical, internal lens to expand provider perspectives. It begins by assuming shared power between members of equal but different cultures and acknowledges that co-learning and co-creating can occur.

Transformative education of culture is a process. Students learn the lifetime skills of critiquing presumptions, reflecting on beliefs, and using their heads and hearts to develop inclusiveness. "Cognitive knowledge about each culture is less important than the ability to communicate, learn and change (Duffy: 491)."

Duffy recommends this framework:

- Start with a basis in cultural theory including key concepts such as ethnocentrism, acculturation, high versus low context, collectivism versus individualism, and free will versus determinism. The goal here is to develop a multicultural perspective that acknowledges the individual (not the professional) as the expert on his or her own multiculturalism. This defines the self as a cultural being and teaches that culture is multileveled, dynamic and relative.
- Include guided work to seek "universal commonalities"—what do we have in common (versus what makes us different). These are easiest to define when in context—learn them by working directly with other cultures. Include opportunities to work directly with other cultures throughout the curriculum.
- Gain cognitive knowledge from diverse sources such as readings, discussions and cultural events.

3. Culturally competent health systems and organizations

There is overlap between approaches recommended for systems and those recommended for training in the literature with similar basic components are at the core. The goal is to have providers, agencies, organizations and systems that function in a culturally competent manner across a continuum of services.

Here are some systems and organizational examples of models for cultural competence.

a) Culturally competent organizations and systems
Betancourt, Green and Carillo 2002
Organizational cultural competence involves maximizing diversity within health care leadership and the health care workforce. Programs to accomplish this may include:

- Establish/strengthen programs for minority health care leadership and development.
- Hire and promote minorities in the health care workforce.
- Involve community representatives in planning and quality improvement meetings of health care organizations.

Systemic cultural competence needs to address initiatives such as:

- Conducting community assessments.
- Developing mechanisms for community and patient feedback.
- Implementing systems for patient racial, ethnic and language preference data collection, developing quality measures for diverse patient populations.
- Ensuring culturally and linguistically appropriate health education materials and health promotion and disease prevention interventions.

Programs to accomplish this may include:

- On site interpreter services if a significant population of Limited English Proficiency (LEP) patients.
- Health information written at the appropriate literacy level, targeted with language and cultural norms.
- Using research tools to detect medical errors due to lack of systemic cultural competence.
- Collect data—race, ethnicity and language preferences. Use it to monitor disparities in health care.

Examples of models of culturally competent care within organizations follow in the text box.

White Memorial Medical Centre Family Practice Residency Program, Los Angeles, CA
Required curriculum includes a month long orientation of residents to the community. Students learn about traditional healers, community-oriented primary care, hold small group discussions, readings, and self-reflective exercise. Issues related to cultural competence are integrated into teaching and in a manual. Residents present cases to faculty regularly emphasis on the socio-cultural perspective. Note: there has been no assessment of program effectiveness yet.)

Language interpreter service and translations, Washington State
This language and interpreter service was introduced in 1991. The centre runs a certification and training program for interpreters and translators.

Kaiser Permanente, San Francisco CA
This health care centre established a department of multicultural services providing on-site interpreters in 14 languages and dialects. They also set up a Chinese interpreter call centre to help Chinese-speaking people make appointments, get medical advice and navigate the health care system. There is also a translation unit. They hire multi-specialty and multidisciplinary staff, chosen for cultural understanding and language proficiencies.

Sunset Park Family Health Centre, Brooklyn NY
This is an example of intervention in community-oriented primary care, with cultural competence already well established within their mandate and mission. They first focus on reducing barriers to care by providing flexible hours, interpretation services, translating signage, forming strong links to community leaders, training Chinese-educated nurses in upgraded clinical skills to pass state exams. They now fund regular staff training programs. They offer patient navigators, expand relationships with community groups, and work to create an environment that celebrates diversity.

b) Five components for cultural competence in healthcare delivery
Campinha-Bacote 2001 and 2003

A five-component system for cultural competence in healthcare delivery, which focuses on five interdependent components: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. These are linked in that cultural desire is seen as the "volcano" that erupts to allow a person to genuinely seek cultural encounters, obtain cultural knowledge, construct culturally sensitive assessments and be humble to the process of cultural awareness.

Campinha-Bacote (2001) outlines a model for cultural competence that includes five main components:

1. Cultural awareness.
2. Cultural knowledge.
3. Cultural skill.
4. Cultural encounters.
5. Cultural desire.

These five components are interdependent. They provide a framework for the delivery of culturally competent services and are outlined in greater detail below. They can be the basis for training for providers and systems to work towards cultural competence.

1. Cultural awareness: the self-examination and in-depth exploration of one's own culture and professional background, recognizing biases, assumptions and prejudices.

2. Cultural knowledge: the process of seeking and obtaining an information base about diverse cultural and ethnic groups. Here, it is important to focus on three issues (Lavizzo-Mourney cited by Campinha-Bacote: 50).

- health-related beliefs and cultural values (understanding client's world view);
- disease incidence and prevalence (who is more at risk for certain diseases, epidemiological data);
- treatment efficacy (ethnic pharmacology, variations in drug metabolism).

Again, a caution, as "no individual is a stereotype of his or her culture of origin, but rather a unique blend of the diversity found within each culture, a unique accumulation of life experiences, and the process of acculturation to other cultures. In the end, it is our clients, not a book, workshop, seminar nor website, who are the true experts of their unique cultural values and practices" (Campinha-Bacote: 49).

3. Cultural skill: the ability to collect relevant cultural data on clients' present problem and accurately perform a specific physical assessment.

Campinha-Bacote provides tools for gaining such data, but reinforces the fact that this component is more than simply choosing tools and asking the right questions. It is more about listening and learning, in a culturally sensitive manner, with interest and without judgment.

More than communication skills are needed. Providers need specific skills to provide a range of services appropriate to each client's physiological, biologic and physiological variations (such as differences in body structure, skin colour, visible physical characteristics, weight, height, and lab variances).

Campinha-Bacote recommends ETHNIC, LEARN and BATHE as tools for data collection.
See: Tools and Resources, page 34-35.

Mastering cultural skills includes addressing linguistic needs—trained interpreters may be needed (they are preferable to family and friends).

4. Cultural encounters: a process that encourages engagement in cross-cultural interactions with clients from diverse backgrounds. Interacting in this way will refine or modify existing beliefs about cultural groups and prevent stereotyping. This is a lifelong process.

5. Cultural desire: the motivation to "want to" engage in the process of becoming culturally aware, knowledgeable and skillful instead of thinking of it as a requirement. This can be realized only when a provider has a good understanding of one's self. This

includes a genuine passion to be open to others and willingness to learn from others as cultural informants. Again, it is a lifelong process.

c) A culturally competent community care model (CCCC)
Kim-Goodwin, Clarke and Barton 2001
A model including four dimensions of culturally competent community care: caring, cultural sensitivity, cultural knowledge and cultural skills

Kim-Goodwin, Clarke and Barton (2001) propose a model that positions community-based care on a continuum from individual-focused health to whole community and population-focused health and health care.

They outline four dimensions of cultural competence:
1. Caring. There is no consensus on the definition or process for 'care'. It includes the will to care, the intent to care, and caring actions plus attitudes, judgments, and actions that support and allow for caring to occur.
2. Cultural sensitivity. Affective aspects of care (respectful attitudes, perceptions and values that show heightened awareness towards your own culture and that of another person)
3. Cultural knowledge. The cognitive understanding of culture-specific skills and behaviours
4. Cultural skills. Abilities obtained in cultural assessment, advocacy and communication needed to prove care. Language skills are included here.

This is the only comprehensive model thus far locating cultural competence in community settings. Culturally competent staff can resolve issues between cultural systems, health systems and community systems.

d) US Institute of Medicine Report recommendations for healthcare systems
IOM report recommends increased minority representation among health professionals, better communication, interpretation services, community health workers and cross-cultural education

The IOM, commissioned by the US Congress, produced a key report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002*)*, found a consistent body of research showing significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. This research indicates that US racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services.

The report includes the following recommendations to attempt to reduce these disparities:
- Increase the proportion of under-represented racial and ethnic minorities among health professionals.
- Enhance patient-provider communication and trust.
- Support the use of interpretation services.

- Support the use of community health workers.
- Integrate cross-cultural education in the training of all current and future health care providers.

e) Culturally competent healthcare institutions

Kagawa-Singer, M and S Kassim-Lakha 2003

The authors outline proposed institutional changes to promote and support culturally competent practice.[7] They outline a two-part evaluation question:

- "Does the adoption of a multifaceted, strategic cultural competence initiative by senior/executive management and the board improve the level of culturally competent care provided by the institution?
- Does the implementation of a cultural competency-training program for health care professionals result in (1) improved patient satisfaction and (2) equal health outcomes across all ethnic groups being served by the health care organization?

Other proposed but untested measures of structure and process include:

- level of representation of cultural diversity among physicians, management and nursing staff;
- management support and accountability for cultural competence training of staff;
- staff motivation to participate in training; multidisciplinary participation in training;
- employee awareness of cultural competency strategic initiative;
- achievement of related management goals;
- integration of cultural competency principles into ongoing service delivery; and, finally,
- degree of institutionalization of cultural competence values, e.g., in menus, patient entertainment, patient education, hospital rules and regulations such as religious observances, and attention to assigning or consulting gender-appropriate caregivers.

Such changes should be reflected in measures of patient satisfaction, although current patient satisfaction questionnaires themselves need to be validated for cross-cultural assessment purposes. Indicators such as better adherence to medical care, follow-up appointments, health care utilization patterns, modification of high-risk health behaviors, promotion of culturally-based health protective behaviors, and reductions in disparities of health outcomes across culturally diverse groups are also important outcome measures."

Steps to implementing culturally based systems:

1. Be aware of our own beliefs, values, and biases.
2. Increase the accuracy of the clinical assessment by conducting a "RISK" reduction assessment, in a culturally informed, patient-centered medical interview rather than using culture or race as stereotypical explanatory factors.

[7] The material in this section is an exact quotation from the authors. It is not altered in any way in order to capture the exact nature of the evaluation questions.

3. Initially, using models of quality of care and patient satisfaction familiar to most health practitioners, health care agencies can institutionalize structural and systemic changes to provide optimal care for all patients."

f) US National Centre for Cultural Competence framework

The National Center for Cultural Competence (NCCC) embraces a conceptual framework and model of achieving cultural competence adapted from the work of Cross et al., 1989.

Cultural competence requires that organizations and their personnel have the capacity to:
1. Value diversity.
2. Conduct self-assessment.
3. Manage the dynamics of difference.
4. Acquire and institutionalize cultural knowledge.
5. Adapt to the diversity and cultural contexts if individuals and communities served.

g) Standards for culturally and linguistically appropriate services

US Department of Health and Human Services, Office of Minority Health, 2001[8]

The US Office of Minority Health recommended national standards for Culturally and Linguistically Appropriate Services (CLAS) to support a more consistent and comprehensive approach to cultural and linguistic competence in health care.

A comprehensive final report on the project, National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care Final Report, was completed in March 2001. The final report describes 14 individual standards and outlines the development, methodology and analysis undertaken to create the national standards (see: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.)

US National Standards for Culturally and Linguistically Appropriate Services
See: Tools and Resources, page 31.

4. Self-assessment and cultural competence

"As is the case for most tasks of this nature, the first steps, at both the individual and societal levels, are honest self-examination and the acknowledgement of need." (Geiger 2001: 1700) Given that one key component for both systems and individuals to achieve cultural competence is increased self-awareness with a critical examination of beliefs, values and biases. One good way to do this is to take part in a self-assessment. These can be carried out by health care organizations or by individual practitioner. Self-Assessment is said to be an essential element of cultural competence.

[8] http://www.omhrc.gov/cultural/standards.htm

The US National Centre for Cultural Competence (NCCC) points out that cultural and linguistic competence develop over time and that organizations and individuals are at various levels of awareness, knowledge and skills along a continuum.

> "Assessing attitudes, practices, structures and policies of programs and their personnel is a necessary, effective and systematic way to plan for and incorporate cultural and linguistic competency within organizations.
>
> There are a wealth of tools that allow both individual providers and systems to assess their current level of cultural competence. These range from simple to elaborate, short to long self-assessment questionnaires. Self-assessments allow providers, policy-makers and system administrators to see where they have strengths, knowledge and information and also to identify their weaknesses, areas that need further research, training and/or administrative consideration" (NCCC 2005).

Tools for Self Assessment
See: Tools and Resources, page 28.

5. Compendium of cultural competence initiatives in health care

A recent (2003) compendium of initiatives for cultural competence has been created by Rees and Ruiz, Kaiser Family Foundation. This provides a tabular summary of public, private and state initiatives to address cultural competence across the United States. It is an excellent all-round resource for searching for practical projects that have been completed, especially training, assessment, evaluation and standards.

Tools and Resources: Kaiser Family Foundation
Compendium of Cultural Competence Initiatives in Health Care
See: http://www.kff.org/uninsured/6067-index.cfm

III. Tools and Resources

1. Web-based Sources of Information on Cultural Competence

US National Centre for Cultural Competence
Designed to increase the capacity of health and mental health programs to design implement, and evaluate culturally and linguistically competent service delivery systems
http://gucchd.georgetown.edu/nccc/index.html

University of Michigan Program for Multicultural Health
http://www.med.umich.edu/multicultural/
(see: Cultural Competency Division)

Kaiser Family Foundation
Resources on minority health
http://www.kff.org/minorityhealth/index.cfm

Biweekly Multicultural Health Generalizations
http://www.med.umich.edu/multicultural/ccp/bmhg.htm

Culturally Competent Outreach
This is a complete training module for training outreach workers working with the homeless.
http://www.nhchc.org/Curriculum/module2/module2D/module2d.htm

Diversity Web
A comprehensive compendium of campus practices and resources for including diversity in higher education
http://www.diversityweb.org/index.cfm

Cultural Competency: College of Medicine, University of South Carolina
A website focusing on cultural competency in health professional education
http://etl2.library.musc.edu/cultural/index.php

Society of Teachers of Family Medicine (STFM) Core Curriculum Guidelines
Recommended core curriculum guidelines on culturally sensitive and competent health care
http://www.stfm.org/corep.html

American Medical Association (AMA)
a) Diversity in Medicine resources
http://www.amsa.org/div/divres.cfm#general

b) PRIME Diversity Project

The PRIME project was designed to encourage and support primary care medical students by developing specialized curricula that emphasize the practical knowledge and skills necessary to meet the unique needs of underserved populations
http://www.amsa.org/programs/prime.cfm

Center for Healthy Families and Cultural Diversity
Dedicated to leadership, advocacy, and excellence in promoting culturally responsive, quality health care for diverse populations--a resource for technical assistance, consultation, and research/evaluation services
http://www2.umdnj.edu/fmedweb/chfcd/INDEX.HTM

George Washington University Medical Center's Cultural Competence Module
Training modules on cultural competence
http://www.gwu.edu/~iscopes/Cultcomp.htm

National Multicultural Institute (NMI)
A collection of educational materials on diversity and cultural competency
http://www.nmci.org

Multicultural Pavilion
Resources for educators, students, and activists to explore and discuss multicultural education; facilitate opportunities for educators to work toward self-awareness and development; and provide forums for educators to interact and collaborate toward a critical, transformative approach to multicultural education
http://curry.edschool.virginia.edu/go/multicultural/

University of Toronto Cultural Competency
An online Handbook of resources on self-development in knowledge and skills pertaining to diversity issues
http://www.phs.utoronto.ca/cultural_competency/mainmenu.htm

Transcultural CA.R.E. Associates
The website of Dr. Josepha Campinha-Bacote, a wealth of knowledge and expertise on cultural competence including tools, articles, models and links
www.transculturalcare.net

Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies
An eleven-section curriculum for teaching clinicians to recognize cultural differences in patient interactions and use specific communication skills to improve patient care
http://futurehealth.ucsf.edu/cnetwork/resources/curricula/diversity.html

2. Self-assessments

a) Self-assessment tools available from US NCCC

Organizational self-assessment tools

- Cultural and Linguistic Competence Self-Assessment Questionnaire (Mason) adapted for organizational self-assessment
- Cultural Competence Policy Assessment (CCPA)
- Policy brief series with checklists for organizations that focus on cultural competence, linguistic competence, community engagement, and research.

Individual self-assessment tools

- Four self-assessment checklists to heighten awareness and sensitivity to the importance of cultural and linguistic competence, that specifically focus on personnel in early childhood, early intervention, primary health care, mental health, children and youth with special health care needs and Sudden Infant Death Syndrome (SIDS)/and infant mortality.
- Cultural Competence Health Practitioner Assessment (CCHPA)

b) Sample Brief Practitioner Self-Assessment

Are you providing culturally competent care?

- Name two diseases/conditions that are influenced by racial/ethnic factors. Explain.
- Describe two cultural values or beliefs that influence how a cultural group, different from your own, responds to being sick.
- Do you respect differences in health behaviors practiced by your client?
- Name two ways in which your practice is responsive to the needs of diverse groups.
- Do you take culture, gender, and race into consideration when examining risk factors faced by your clients?
- Do you involve your clients in the decision making when considering a course of treatment?
- What is a question you commonly ask to learn about your clients' ethnic, or sociocultural background? How is this information relevant to your practice?

Add up your score. Give yourself 1 point for each item named on questions 1, 2, 4, and 7. Give yourself 1 point for a Yes on questions 3, 5, and 6.

Score 9-10: Good work, keep it up! Cultural competence is a continuous quality improvement process.
Score 2-8: Keep working, you have a way to go. Check out the links to related sites.
Score 0-1: Better start developing your competency skills. Begin by reading the suggested resources.

Source: www.culturalcompetence2.com/ceoupdatefall99.html

c) ASKED

ASKED is an informal assessment for healthcare professionals to assess their level of cultural competence (Campinha-Bacote 2002).

Have I 'ASKED' Myself The Right Questions?"

A wareness

Am I aware of my biases and prejudices towards other cultural groups, as well as racism in healthcare?

S kill

Do I have the skill of conducting a cultural assessment?

K nowledge

Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledge in the field of biocultural ecology?

E ncounters

Do I seek out face-to-face, and other types of interactions with individuals who are different from myself?

D esire:

Do I really "want to" become culturally competent?

Source: Campinha-Bacote 2002, www.transculturalcare.net/ (see: Models of Cultural Competence)

d) IAPCC-R Assessment

The Inventory For Assessing The Process of Cultural Competence Among Healthcare Professionals - Revised (IAPCC-R) was developed by Dr Campinha-Bacote. It is based on her model of cultural competence and has established reliability and validity.

Source: Campinha-Bacote 2002, www.transculturalcare.net (see: IAPCC-R and Other Cultural Assessment Tools)

e) Other provider assessments

Quality and Culture Quiz: A 23-question quiz to examine your own cultural competence from the Provider's Guide to Quality and Culture
http://erc.msh.org/mainpage.cfm?file=3.0.htm&module=provider&language=English

Health Practitioner Assessment: A Cultural Competence Health Practitioner Assessment developed by the National Center for Cultural Competence
https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?formID=277

f) Performance assessment for patient-centered communication for vulnerable populations

A draft framework of nine content areas, recommending performance assessment in the following stages:

Content Area 1: Understand Your Organization

Organizations should routinely examine their commitment, capacity, and efforts to meet the communication needs of their patients, including leadership involvement; mission, goals, and strategies; policies and programs; budget allocations; and staff values.

Content Area 2: Collect Data
Organizations should use standardized qualitative and quantitative data collection methods and uniform coding systems to gather valid and reliable information for understanding the demographics and communication needs of the patients they serve.

Content Area 3: Engage Communities
Organizations should make demonstrable, proactive efforts to understand and reach out to the communities they serve, including establishing relationships with community groups and developing opportunities for community members to participate in shaping organizational policies.

Content Area 4: Develop Workforce
Organizations should ensure that the structure and capability of their workforce meets the communication needs of their patient populations, including employing and training a workforce that reflects and appreciates the diversity of the communities that the organization serves.

Content Area 5: Engage Patients
Organizations should help staff to engage all patients, especially those from vulnerable populations, through quality interpersonal communication that safely and effectively elicits health needs, beliefs, and expectations; builds trust; and conveys information that is understandable and empowering.

Content Area 5a: Socio-Cultural Context
Organizations should create an environment that is respectful to patients of diverse backgrounds; this includes helping staff to understand the socio-cultural factors that affect patients' health beliefs and ability to interact with the health care system.

Content Area 5b: Language Assistance
Organizations should determine what language assistance is required by their current and potential patients, make the assistance routinely available, and train staff on how to access and use those materials and services.

Content Area 5c: Health Literacy
Organizations should consider the health literacy level of their current and potential patients and use this information to develop a strategy for the clear communication of medical information verbally, in writing, and using other media.

Content Area 6: Evaluate Performance
Organizations should regularly monitor their performance with regard to each of the prior content areas using structure, process, and outcome measures, and make appropriate adjustments on the basis of these evaluations.

Source: http://www.ama-assn.org/ama/pub/category/12759.html

3. Recommended Standards for Culturally and Linguistically Appropriate Health Care Services

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

- Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

- Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

- Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.

- Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

- Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

- Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

- Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.

- Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in service areas.

- Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

- Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.

- Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

- Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

- Develop structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

- Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

Source: US Department of Health and Human Services, Office of Minority Health
http://www.omhrc.gov/clas/ds.htm

4. Tools for cross-cultural communication

Several training programs for cross-cultural communication use these memory triggers and other questioning techniques to outline the key steps for cross-cultural understanding and negotiation.

a) E.T.H.N.I.C.

Levin, S, Like, R and Gottlieb1998

Explanation	of the problem/condition by the client
Treatment	or home remedies used and treatment sought
Healers	and other nonprofessionals from whom client seeks advice
Negotiation	of mutually acceptable options
Intervention	that includes client's beliefs and practices
Collaboration	with client, family healers and community resources

EXPLANATION

- What do you think may be the reason you have these symptoms?
- What do friends, family, others say about these symptoms?
- Do you know anyone else who has had or who has this kind of problem?
- Have you heard about it on TV or radio or read about it in a newspaper? (If patient cannot offer explanation, ask what most concerns them about their problems).

TREATMENT

- What kinds of medicines, home remedies, or other treatments have you tried for this illness?
- Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it.
- What kind of treatment are you seeking from me?

HEALERS

- Have you sought any advice from alternative/folk healers, friends, or other people (non-doctors) for help with your problems? Tell me about it.

NEGOTIATE

- Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate, your patient's beliefs. Ask what are the most important results your patient hopes to achieve from this intervention.

INTERVENTION

- Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g., foods eaten or avoided in general, and when sick).

COLLABORATION

- Collaborate with the patient, family members, other health care team members, healers, and community resources.

Source: Developed by: Steven J. Levin, MD Robert C. Like, MD, MS Jan E. Gottlieb, MPH Center for Healthy Families and Cultural Diversity Department of Family Medicine UMDNJ-Robert Wood Johnson Medical School. Under copyright. http://www.state.nj.us/health/bibs/education/ethnic.html

b) L.E.A.R.N

Guidelines for Overcoming Obstacles in Cross-Cultural Communication with Patients
Berlin and Fowkes (1983)

L Listen with empathy and understanding of the patient's perception of the problem
E Explain your perceptions of the problem
A Acknowledge and discuss the differences and similarities
R Recommend treatment
N Negotiate agreement

c) B.A.T.H.E

Stuart and Lieberman (1993)

B Background—What is going on in the client's life?
A Affect—How does the client feel about the problem or condition?
T Trouble—What about the situation troubles the client?
H Handling—How does the client handle the problem or condition?
E Empathy—Provide psychological support to the client

d) Patient's Health Beliefs Assessment Guide

Kleinman, Eisenberg, and Good (1978)

- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you?
- How does it work?
- How severe is your sickness? Will it have a long or short duration?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused you?
- What do you fear most about your sickness?

e) Communication interviewing questions

Eliciting patient information and negotiating

I. Exploring the Meaning of the Illness
Explanatory Model

- What do you think has caused your problem? What do you call it?
- Why do you think it started when it did?
- How does it affect your life?
- How severe is it? What worries you the most?
- What kind of treatment do you think would work?

The Patient's Agenda

- How can I be most helpful to you?
- What is most important for you?

Illness Behavior

- Have you seen anyone else about this problem besides a physician?
- Have you used nonmedical remedies or treatments for your problem?
- Who advises you about your health?

II. Social Context: Review of Systems

Control Over Environment

- Is money a big problem in your life? Are you ever short of food or clothing?
- How do you keep track of appointments? Are you more concerned about how your health affects you right now or how it might affect you in the future?

Change in Environment

- Where are you from?
- What made you decide to come to this country (city, town)? When did you come?
- How have you found life here compared to life in your country (city, town)? What was medical care like there compared with here?

Social Stressors and Support Network

- What is causing the most difficulty or stress in your life? How do you deal with this?
- Do you have friends or relatives that you can call on for help? Who are they? Do they live close to you?
- Are you very involved in a religious or social group? Do you feel that God (or a higher power) provides a strong source of support in your life?

Literacy and Language

- Do you have trouble reading your medication bottles or appointment slips?
- What language do you speak at home? Do you ever feel that you have difficulty communicating everything you want to say to the doctor or staff?

III. NEGOTIATION

Negotiating Explanatory Models

Explore patient's explanatory model

- Determine how the explanatory model differs from the biomedical model and how strongly the patient adheres to it.
- Describe that biomedical explanatory model in understandable terms, using as much of the patient's terminology and conceptualization as necessary.
- Determine the patient's degree of understanding and acceptance of the biomedical model as it is described.
- If conflict remains, reevaluate core cultural issues and social context.

Negotiating for Management Options

- Describe specific management options (tests, treatments, or procedures) in understandable terms.
- Prioritize management options.
- Determine the patient's priorities.
- Present a reasonable management plan.
- Determine the patient's level of acceptance of this plan (do not assume acceptance - inquire directly).
- If conflict remains, focus negotiation on higher priorities.

Source: Adapted from: Carillo J.E., Green A.R., Betancourt J.R. “Cross cultural primary care: a patient-based approach”. *Ann Intern Med.* 1999;130:829-34.

Conclusions and recommendations

Attention to cultural competence is crucial to the success of primary health care approaches. Cultural competence is a growing and dynamic field of study, generating a substantial body of literature. This report merely skims the surface of this literature, summarizing some key definitions and outlining strategies for approaching cultural competence with providers, agencies and systems. It also includes useful tools and resources that may assist in the creation of local cultural competence strategies.

Having considered this subject, the authors propose the following recommendations:

- Conduct an environmental scan to determine what cultural competence initiatives have been implemented and are currently underway in the Capital District.
- Take a planned, interdisciplinary and culturally diverse strategic approach.
- Targeting specific sectors, complete further research on programs and resources in other areas.
- Start by increasing awareness of the need for cultural competence.
- Increase the proportion of under-represented culturally diverse minorities among primary health care professionals.
- Learn more about the culturally diverse communities and individuals you serve. Enter their world.
- Enhance client-provider communication and trust.
- Support the use of interpretation services if requested by the communities you serve.
- Increase knowledge of traditional healers and alternative health care providers within the community served.
- Consider literacy in communicating with clients and in population health promotion.
- Support the use of community health workers.
- Integrate transformative cultural education in the training of all current and future providers and staff.

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