Developing, Implementing, and Evaluating Cultural Competency Training Programs: What Are We Learning?

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Presented at the Migrant Friendly Hospital Conference
“Hospitals in a Culturally Diverse Europe”
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Objectives

- Define the concept and rationale for culturally competent health care
- Present a model for cultural competence education and training that can be used to guide curriculum development
- Discuss content and strategies related to cultural awareness, skills, knowledge, encounters, and desire that can be included in cultural competence curricula
Objectives

- Share findings and lessons learned from a recently completed cultural competency training/quality improvement study in two academic family medicine settings in the U.S.
- Describe resources that can facilitate the delivery of culturally and linguistically appropriate services
Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches: Final Report

Authors: JR Betancourt, AR Green, JE Carrillo
October 2002

Project funded by the Commonwealth Fund
www.cmwf.org
What is Cultural Competence?

“The ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients’ social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency.”

The Commonwealth Fund. New York, NY, 2002
Rationale for Culturally Competent Health Care

- Responding to demographic changes
- Eliminating disparities in the health status of people of diverse racial, ethnic, & cultural backgrounds
- Improving the quality of services & outcomes
- Meeting legislative, regulatory, & accreditation mandates
- Gaining a competitive edge in the marketplace
- Decreasing the likelihood of liability/malpractice claims

Institute of Medicine Reports

In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce (2003)


Crossing the Quality Chasm: A New Health System for the 21st Century (2001)

To Err is Human: Building a Safer Health System (1999)
National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care

Final Report

DHHS Office of Minority Health

Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency ("Revised HHS LEP Guidance," issued pursuant to Executive Order 13166)
Emerging Accreditation Requirements and Guidelines

- Liaison Committee on Medical Education

- Accreditation Council for Graduate Medical Education

- Joint Commission on Accreditation of Health Care Organizations

- National Committee on Quality Assurance
The Business Case for Cultural Competence

“The collective buying power of African Americans, Asian Americans, Latinos and American Indians is projected to reach $4.5 trillion by 2015.”

Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals

Cultures in the Clinic Project
Jean Gilbert, PhD, Chair and Editor
Julia Puebla Fortier, Co-Chair and Expert Consultant

Funded by the California Endowment
CULTURAL COMPETENCE EDUCATION

Nursing <-> Medicine <-> MH/SA

Oral Health <-> Public Health

Allied Health <-> Pharmacy <-> Social Work
Professional Medical Organizations

The following specialty groups have published guidelines and/or policies relating to the care of culturally diverse populations:

- Society of Teachers of Family Medicine
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Obstetrics and Gynecology
- American Psychiatric Association
- American College of Emergency Physicians
The ASKED Framework

A - Awareness
S - Skill
K - Knowledge
E - Encounters
D - Desire

Cultural Awareness

“Cultural awareness is the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients’ cultures .... This awareness process must involve examination of one’s own prejudices and biases toward other cultures and in-depth exploration of one’s own cultural background.”

The Health Care System

Popular Sector

- Individual-based
- Family-based
- Social nexus-based
- Community-based

Professional Sector

Folk Sector

Adapted from Kleinman A: Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry, Berkeley, University of California Press, 1980
Key Points

- Within-group diversity is often greater than between-group diversity
- There is no “cookbook approach” to treating patients
- Avoid stereotyping and overgeneralization
- An assets and strengths-based perspective is important to maintain
- Every encounter is a cross-cultural encounter
Cultural Skills

“Cultural skill is the ability to collect relevant cultural data regarding the clients’ health histories and presenting problems as well as accurately performing a culturally specific physical assessment.”

Guidelines: Complementary Cultural Formulation

1. Cultural Identity of the Client
2. Cultural Explanations of the Client’s Illness
3. Cultural Factors Related to Psycho-Social Environment and Disabilities
4. Intercultural Considerations on the Provider-Client Relationship

DSM-IV, American Psychiatric Association
Guidelines for Health Practitioners: *LEARN*

L : Listen with sympathy and understanding to 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.

Cultural Knowledge

“Cultural knowledge is the process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures … [T]he process … also involves obtaining knowledge regarding specific physical, biological, and physiological variations among ethnic groups.”

General Topics

- Historical and contemporary experiences of migrant and multicultural populations
- Changing demographics in the general population and health professions workforce
- Disparities and inequities in access to health care, utilization, quality, and outcomes
What Leads to Disparities in Health?

- Social Determinants
  - Education, environment, housing, employment

- Access to Care
  - Insurance, continuity of care

- Health Care
  - Health systems & the medical encounter

Developed by Joseph Betancourt, MD, MPH, Harvard Medical School
Racism in Medicine and Public Health


Caring for Diverse Populations

- Human Genome Project
- Evidence-Based Multicultural Medicine
- Culturally Responsive Clinical Practice Guidelines and Disease Management
- Ethnopharmacology
- Complementary/Alternative/Integrative Medicine
Cultural Encounters

“Cultural encounter is the process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds.”

Linking Communication to Outcomes

How do we link communication to outcomes?

Communication → Patient Satisfaction → Adherence → Health Outcomes

Developed by Joseph Betancourt, MD, MPH, Harvard Medical School
Strategies to Overcome Linguistic and Cultural Barriers

- Bilingual/Bicultural Providers
- Bilingual/Bicultural Community Health Workers
- Employee Language Banks
- Professional Interpreters
- Written Translation Materials

Cultural Desire

“Cultural desire is the motivation of health care providers to ‘want to’ engage in the process of cultural competence.”

The Need for Cultural Humility

- A lifelong commitment to self-evaluation and self-critique
- Redressing power imbalances
- Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations

Evidence Base for Cultural Competency

Can Cultural Competency Reduce Racial & Ethnic Health Disparities? A Review and Conceptual Model

Strategies for Improving Minority Healthcare Quality

Setting the Agenda for Research on Cultural Competence in Health Care: Final Report
Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods

Center for Healthy Families and Cultural Diversity
Department of Family Medicine
UMDNJ-Robert Wood Johnson Medical School

January 1, 2002 - December 31, 2003

Project funded by the Aetna Foundation
2001 Quality Care Research Fund
Study Design

**Locations:**
2 urban Family Practice Centers in the Northeastern U.S. affiliated with a medical school

**Timeframe:**
15 months

**Human Subjects:**
IRB-Approved
HIPAA Compliant
Voluntary Participation/
Anonymity
Written Informed Consent
Project Substudies

- Substudy 1: Addressing the CLAS Standards
- Substudy 2: Increasing Cultural Competency
- Substudy 3: Providing Patient-Centered Care
- Substudy 4: Improving Quality in Primary Care Practice Settings
Substudy 1 -
Research Question

What are the views and perspectives of physicians, staff, and patients on addressing the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care in a family practice setting?
Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile

The Lewin Group
HRSA/DHSS
April 2002
http://www.hrsa.gov/OMH/cultural1.htm
Organizational Cultural Competence Assessment Profile Components

**DOMAINS & FOCUS AREAS**

- Organizational Values
- Governance
- Planning & Monitoring/Evaluation
- Communication
- Staff Development
- Organizational Infrastructure
- Services/Interventions

**INDICATORS**

- Structure
- Process
- Output

**OUTCOMES**

- Organizational
- Client
- Community

The Lewin Group
April 2002
Addressing the CLAS Standards

- Four Depth Interviews were held with the Medical Directors and Practice Managers

- Six Focus Group Interviews were conducted with physicians, staff, and patients at the two study sites
Q: Medical Directors - What do you think is needed as far as cultural competence education for providers and staff?

- “Ongoing training activities that are continuous to improve our knowledge, skills, and attitudes.”
- “Dealing with the question of stereotype vs. cultural awareness. Where on that continuum do you fall? And where is the truth in that?”
- “We don’t even know how to take a family history from different ethnic groups. We do it all the same way.”
Staff Development - Depth Interviews

Q: **Office Managers** - What do you think is needed as far as cultural competence education for providers and staff?

- “If you teach about cultures you have to keep some general ideas, some general rule, or certain fundamental ideas about cultures. Where does the stereotyping begin and where does cultural awareness begin?”

- “I have seen emails going by from physicians and others in the office about where they can find information on cultural competence and how can we educate ourselves.”
Q: **Physicians** - What do you think is needed as far as cultural competence education for providers and staff?

- “I have a real hard time thinking that the only culturally competent care that can occur is when the patient and provider share, at least superficially, share racial/ethnic characteristics. One of the things that [I've learned] is that all encounters are cross-cultural, whether it be people that have the same skin color or same language ability.
- “Treat the individual.”
- “No matter who they are or what culture. You’ve got to keep an open mind … listen to them.”
Q: **Support Staff** - What do you think is needed as far as cultural competence education for providers and staff?

- “We need training, lots of training. We need customer service training. We need to know more about medical care - the kind of problems our doctors take care of. We need to study our problems better. We need to understand them better. I think that problems need more than a simple response. Then we need to correct our problems in a good way, a way to serve our patients better, as well as our fellow workers.”
Staff Development - Focus Group Interviews

Q: Patients - What do you think is needed as far as cultural competence education for providers and staff?

- “I think it’s important to learn about certain cultures, too…like certain cultures do a lot more herbal medicines…physicians need to know that so if they’re asking you what kind of medications are you taking and they say none, but maybe they did take herbal medicines.”

- “Doctors are in a sheltered world as far as I’m concerned…go out to the real world…see what it’s like to live in Newark or Jersey City or Perth Amboy where it’s a little bit tougher.”
Summary

- Physicians, staff, and patients, although initially not fully aware of the CLAS standards, are highly interested in learning about ways to infuse cultural competence into patient care delivery systems.

- There is a desire for additional clinical cultural competency training that focuses on increasing provider knowledge and skills relating to the care of patients from diverse backgrounds.

- Concerns were raised, however, about the dangers of stereotyping and overgeneralization, as well as the environmental, organizational, and fiscal stresses being experienced by primary care practices.
Substudy 2 - Research Question

Does a cultural competency training program result in improved physician knowledge, skills, attitudes, and comfort levels relating to the care of patients from diverse backgrounds?
Assessing Clinical Cultural Competence

Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care

Multicultural Curricula in Family Practice Residencies

Assessing Resident Physician Preparedness to Care for Culturally Diverse Patient Populations
Weissman J, Betancourt J. Institute for Health Policy, Massachusetts General Hospital, Harvard Medical School, Commonwealth Fund, 2004.

A Model and Instrument for Addressing Cultural Competence in Health Care
Cultural Competency for Health Care Providers Training Program

**Purpose:** Raising awareness about racial and ethnic health disparities and diversity issues, and increasing clinical and organizational cultural competence

**Format:** A series of 5, 1.5-hour interactive seminars (total 7.5 hours) presented over an 8-month period

**Attendees:** Faculty physicians, residents, and medical students

**Educational Methods:** Lectures, commercially available videos, interactive case studies, and small group discussions
Cultural Competency Training Sessions

- “Improving the Quality of Care for Diverse Populations”
- “Addressing Racial and Ethnic Health Disparities: Caring for African American Patients with Cardiovascular Disease”
- “The American Academy of Family Physicians' Quality Care for Diverse Populations Cultural Competency Training Program” (e.g., ETHNIC and BATHE mnemonics)
- “Caring for Patients with Limited English Proficiency: An Update” (e.g., Working with Medical Interpreters)
- “Culturally Competent Quality Improvement in Primary Care”
Clinical Cultural Competency Questionnaire (CCMQ)

- **Pre-Training Version** (86 items) - Summer 2002
- **Post-Training Version** (84 items) - Summer 2003

**Measures**
- pre-post changes in self-perceived knowledge, skills, attitudes, and comfort levels related to the delivery of culturally competent health care to diverse populations
CCCQ: Item Content

- **Demographics**
  (pre - 10 items; post - 10 items)

- **Knowledge**
  (pre - 16 items; post – 16 items)

- **Skills**
  (pre - 15 items; post – 15 items)

- **Comfort with Encounters/Situations**
  (pre - 12 items; post – 12 items)

- **Attitudes**
  (pre - 21 items; post – 21 items)

- **Education and Training**
  (pre- 12 items; post – 8 items)

- **Impact**
  (post only – 12 items)
Physician Sample Characteristics

- 15 of 17 faculty physicians successfully completed the pre- and post-training CCCQ surveys -
  6 from Practice A and 9 from Practice B
- 2 physicians who left the practice did not complete the post-training CCCQ survey - results not included
- **Age:** mean 45.6 years (R 33 to 56 years, SD 6.3)
- **Gender:** 53% male; 47% female
- **Ethnicity/Race:** 93% self-identified as Caucasian; 7% Asian American
- **Travel:** 86% visited/lived in countries outside U.S.
- **Language Skills:** 40% bilingual
CCCQ Results

- 7 of the 16 knowledge items show significant improvements (5 at p < .05 and 2 at p < .01)

- 8 of the 15 skills items had significant t-test values (7 at p < .05 and 1 at p < .01)

- 4 of the 12 comfort in encounters items had significant pre-post changes (3 at p < .05 and 1 at p < .01)
Cultural Competency – Self-Perceived Knowledge

Graph of Pre-Post Changes

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<th>CCCQ Knowledge Items</th>
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*p < .05  **p < .01
Cultural Competency – Self-Perceived Skills

Graph of Pre-Post Changes

** CCCQ Skills Items

* p < .05  ** p < .01
Cultural Competency – Comfort with Encounters

Graph of Pre-Post Changes

CCCQ Encounter Items

* p<.05  ** p<.01
Study Limitations

- Small physician sample size
- Self-report vs. observation
- Lack of a control group
- Variable attendance and exposure to training intervention
- Need for further psychometric validation studies of CCCQ
- Potential organizational and environmental confounders
- Need for assessing potential time, site, and person interactions
- Generalizability/transferability issues
Summary

- Physicians’ self-perceived cultural competence knowledge, skills, and comfort levels increased significantly in several subject areas following the training intervention.

- Caution is needed, however, in attributing the positive changes to the cultural competency training due to a variety of potential confounders.

- Research into the assessment of clinical cultural competence is still in its infancy and will benefit from future theoretically-informed, multi-method studies in real world practice settings.
Complexity Science and the Ecology of Health Care

Cultural Competency Training in Health Care Organizations

What is the Current Status?

- “No Talk and No Walk”
- “Talking the Talk”
- “Walking the Talk”
- “Talking and Walking”
Which Curriculum is Being Transformed?

- **Explicit Curriculum**
  - “formal,” “co-,” or “extra-curricular” activities

- **Implicit Curriculum**
  - “hidden” curriculum

- **Null Curriculum**
  - “what is left out of the curriculum”

Adapted from Elliott Eisner (http://www.teachersmind.com/eisner.htm)
CHALLENGES TO TEACHING AND ASSESSING CULTURAL COMPETENCE
Cultural and Linguistic Competency Training

- Monographs/Articles
- Seminars/Workshops/Courses
- Grand Rounds/Conferences
- Curricular Materials/Simulations
- Community Immersion Experiences
- Multimedia - Videos/CD-ROMs/DVDs
- Websites/E-Learning/Blended Learning
National Center for Cultural Competence -- Georgetown University

- Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment
- Planning for Cultural and Linguistic Competence in Systems of Care
- Self-Assessment Checklist for Personnel Providing Primary Health Care Services
- Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs

http://gucchd.georgetown.edu/nccc/products.html
Internet Websites

The Provider’s Guide to Quality and Culture
http://erc.msh.org/quality&culture

Resources for Cross-Cultural Health Care
http://www.diversityrx.org

National Council on Interpreting in Health Care
http://www.ncihc.org

Cross-Cultural Communication in Health Care: Building Organizational Capacity
www.hrsa.gov/financeMD/broadcast
Cultural Competency Curriculum Modules (CCCMs)

http://www.cultureandhealth.org
HEALTH DISPARITIES COLLABORATIVES

Changing Practice/Changing Lives

Institute for Healthcare Improvement and other partners

Funded by the Health Resources and Services Administration
Bureau of Primary Health Care

www.healthdisparities.net
DEVELOPMENTAL MODELS OF CLINICAL AND ORGANIZATIONAL CULTURAL COMPETENCE
Developmental Model of Ethnosensitivity
(Adapted from Bennett)

FEAR
- General
- Specific

DENIAL
- Denigration
- Categorization

SUPERIORITY
- Reversal

MINIMIZATION

RELATIVISM
- Reductionism
- Marginalization
- Universalism

EMPATHY
- Adaptation
- Pluralism

INTEGRATION
- Ethics
- Contextual Evaluation

ETHNOCENTRIC

ETHNOSENSITIVE

The Spectrum of Cultural Competence

Stage 0: Inaction
Stage I: Symbolic Action and Initial Organization
Stage II: Formalized Internal Action
Stage III: Patient and Staff Cultural Diversity Initiatives
Stage IV: Culturally Diverse Learning Organization

Developed by Dennis P. Andrulis, PhD, MPH; SUNY Downstate Medical Center
Cultural Competency as a Type of Innovation

Strategies for Accelerating the Rate of Diffusion of Innovations

- Find sound innovations
- Find and support "innovators"
- Invest in "early adopters"
- Make early adopter activity observable
- Trust and enable reinvention
- Create slack for change
- Lead by example

Cultural Competency Training is Necessary but NOT Sufficient!

Cultural Competency needs to be integrated into ongoing quality improvement activities!
The Future

How can we ... 

- transform ourselves as individuals, organizations, and systems?
- generate interest, deal with resistance, and support the desire to become more culturally competent?
- address historical and contemporary “isms” and “fears”? 
The Future

How can we ...

- evaluate the effectiveness of cultural competency educational programs?
- align the social, economic, and business case for cultural competency training?
- support, institutionalize, and sustain cultural competency training in our health care organizations through partnering with key stakeholders and constituency groups?
“Adding wings to caterpillars does not create butterflies -- it creates awkward and dysfunctional caterpillars. Butterflies are created through transformation.”

Stephanie Pace Marshall