# Cultural Competence: Understanding and Application by Health Care Professionals

Tiana Dorosz

Dr. Anjela Wong, Department of Educational Studies

## Abstract

This project aimed to increase the understanding of cultural competence in health care. According to U.S. Census predictions, around the year 2043, non-Hispanic Whites will drop below 50% of the U.S. population, illustrating an increase in racial diversity. Diversity is also increasing in many fields in terms of gender and sexual orientation as more efforts for equity and inclusion are being put forth. Cultural competence is essential to eliminate disparities and ensure quality care for minoritized individuals. Virtual interviews were conducted with 12 health care professionals. Semi-structured interview questions examined how these professionals define and apply cultural competence in their practices. Participants also reflected on their cultural competency training and available resources. Similar phrases used to define cultural competence included, "cultural knowledge", "desire to learn and change", "ongoing process", and "individualized to the patient". Common phrases used to describe applying cultural competence included "ask", which was used in all 12 interviews, "acceptance", "focus on social determinants of health (SDOH)", "individualized", and "staff collaboration". Potential areas for improvement were revealed, including cultural competence education from Computer Based Trainings (CBTs) and in the hiring process, as well as transgender education. We hope this study provides knowledge of health care professionals' understanding and application of cultural competence and will lead to improvements in health care facilities.

## Introduction

Research on cultural competence can be applied to any discipline, but it can be life saving to study it in the health care field. By 2043, Non-Hispanic Whites will make up less than half of the U.S. population (Yen, 2013). This shows that the U.S. has a growing racially and ethnically diverse population that will be in need of health care services. Therefore, being culturally competent when caring for the community is essential in order to provide quality care for all. In the current U.S. health care system, racially and ethnically minoritized communities often face obstacles when accessing health care, such as language and communication barriers. These obstacles can compromise their quality of care. For example, African Americans and Hispanics are disproportionately burdened by chronic diseases (Collins et al, 2002). Understanding why certain populations may be more susceptible to these chronic diseases can help professionals improve the quality of care provided to these groups, and potentially eliminate health and health care disparities. In addition to racial and ethnic diversity in the U.S., there also is growing diversity in gender and sexual orientation. Both of these factors would be addressed with culturally competent care. Overall, the reasons given here demonstrate the necessity for research on cultural competency in the health care field. The ultimate goal of this project is to provide valuable knowledge of health care professionals' understanding and application of cultural competence that will hopefully lead to improvements in the administration of equitable health care.

## Defining and Modeling Cultural Competence

**Health Care Context** In a health care context, there are a variety of theorists that have contributed to the understanding of cultural competence.
A theorist in the nursing field is Madeleine Leininger, who defines culturally congruent care as:

Those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are tailor made to fit with individual, group, or institutional cultural values, beliefs, and lifeways in order to provide or support meaningful, beneficial, and satisfying health care or well-being services (Leininger, 1991, p. 49).

It is thought that culturally congruent care will lead to more favorable health outcomes and lower costs due to improved communication, better compliance with medical treatment plans, and reduced use of high cost services, such as emergency room visits (Schim et.

al., 2007). Leininger (2002) developed the Culture Care Theory, which remains one of the oldest, most holistic and comprehensive theories regarding this topic. This theory has many unique aspects that set it apart from other theories. It is focused on interlocking relationships between culture and care on well-being, health, illness, and death. Her theory is also the first nursing theory with a designed research method to fit the theory (Leininger, 2002). Throughout the development of Culture Care Theory, nurses faced the sizable challenge of identifying cultural meanings, practices, and beliefs that influence the perceived quality of care. These elements need to be understood for culturally competent care to be provided, and thus, the Sunrise Model (Fig. 1) was created. This model depicts factors that influence care and the interactions between them. It is frequently used by nurses for health care assessments. The model allows nurses to begin with a focus on whichever area they wish, either at the top or bottom of the model (Leininger, 2002). Overall, Culture Care Theory has been a significant contribution that adds to the understanding of cultural competence.

A more recent model of culturally congruent care was created as an extension of Leininger's work, adding in concrete examples and illustrations regarding application of the theory. This is known as the 3D Puzzle Model, (Schim et al., 2007, Fig. 2) which includes both a provider and client level. The provider level includes 4 main "pieces", or constructs: (1) cultural diversity, (2) cultural awareness, (3) cultural sensitivity, and (4) cultural competence (Schim et al., 2007, Fig. 3). Cultural diversity is omnipresent in today's global society, and diversity varies depending on the area in which care is being provided. Cultural awareness, on a base level, involves knowledge and recognition of certain racial, ethnic, and/or religious groups. However, there is significant intra-group variability, making it difficult to learn a set of facts about a particular group. Therefore, this model suggests that a provider should make inquiries regarding cultural practices on an individual basis. Cultural sensitivity refers to approaching the patient or community with humility and taking on the learner role rather than making assumptions of the individual or group. Finally, cultural competence, in this model, refers to the behaviors and actions taken in response to cultural diversity, awareness, and sensitivity. This 3D Puzzle Model reflects the nonlinear and interconnected nature of these constructs and suggests that all four pieces are necessary to achieve culturally congruent care (Schim et al., 2007).

As mentioned in other theories, an important process involved in providing culturally competent care is establishing self-awareness. Nursing professor Dr. Gloria Kersey-Matusiak (2013) provides the Staircase Model as an effort to identify one's own values and existing knowledge as a type of personal reflection. This model has the following "steps": Cultural Destructiveness, Cultural Incapacity, Cultural Blindness, Pre-Competency, Basic Cultural Competency, and Advanced Cultural Competency. At each step, there are different questions that should be used to determine where a provider places themselves, how they can increase self-awareness, and in what ways they can improve their cultural competence. This model differs from the Sunrise Model and the 3D Puzzle Model because it shows distinct steps, illustrating progression "up" the steps rather than ongoing development and shaping of cultural competence.
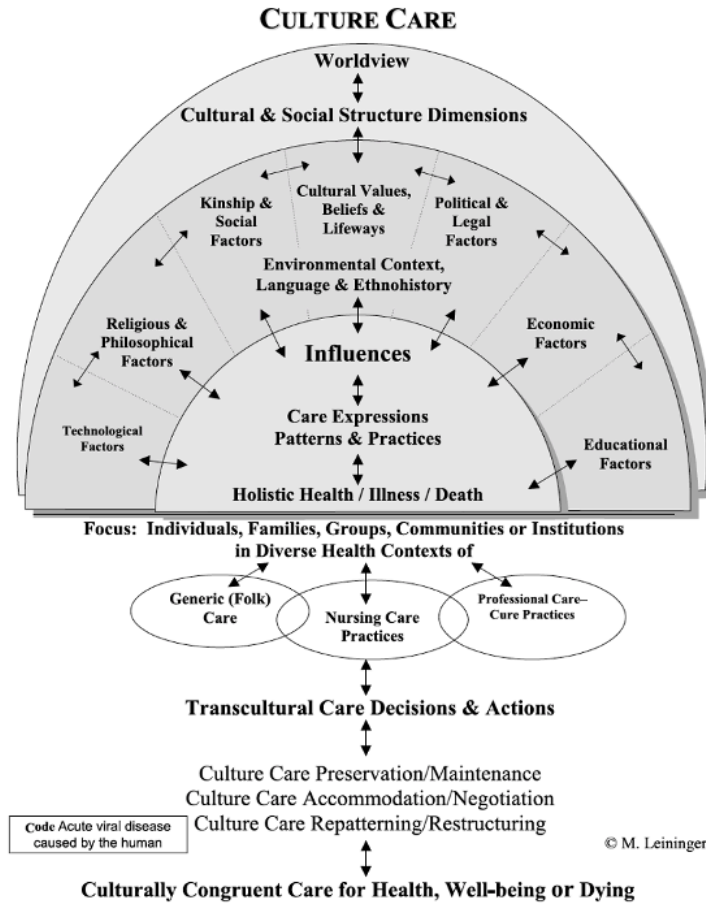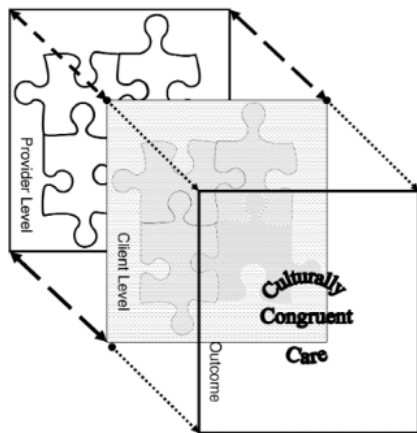
*Figure 1*: Sunrise Model.



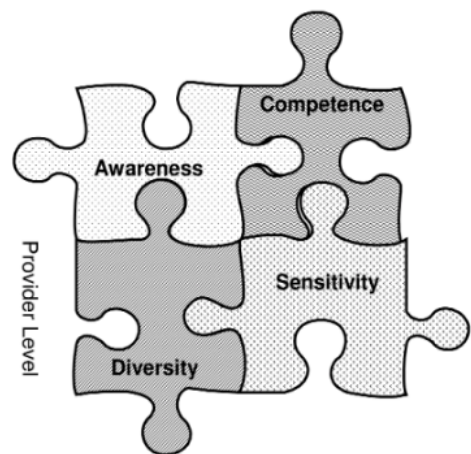*Figure 2*: Culturally congruent care model.



*Figure 3:* Provider level of culturally congruent model.

**Current Interventions**

These theories have led to the creation of various interventions, each with the goal of improving cultural competence in the health care field. For example, many organizations are requiring their staff to undergo training related to diversity and care. A recent survey by the Institute for Diversity in Health Management (2013) shows that 81 percent of hospitals educate all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities, and 61 percent of hospitals require all employees to attend diversity training. Although this is a start, there is still room for improvement. Moving forward, it is important to recognize which interventions are available and how they can be utilized to improve cultural competency.

In a systematic review of culturally competent health care systems, the Task Force on Community Preventive Services evaluated five interventions that were designed to improve providers' cultural competence (Anderson et. al., 2003). These included; "programs to recruit and retain staff members who reflect the cultural diversity of the community served, use of interpreter services or bilingual providers for clients with limited English proficiency, cultural competency training for health care providers, use of linguistically and culturally appropriate health education materials, and culturally specific health care settings" (Anderson et. al., pg. 70). These interventions, variations of them, and others are often utilized to some degree within many health care facilities.

**Guidelines and Standards**

In 1997, the Office of Minority Health developed a set of national standards to guide practices related to culturally and linguistically appropriate health services (Spector, 2017). These 15 standards, which have been improved over time, are called the National Standards for Culturally and Linguistically Appropriate Services (The National CLAS Standards, Appendix A). These standards set the bar for providing equitable health care in many federal and state agencies, as well as other national organizations. According to the U.S. Department of Health and Human Services (2018), they are intended to improve the quality of health care by creating a framework for organizations to serve increasingly diverse communities. Additionally, there are many organizations and groups that have developed other guidelines and initiatives to improve cultural competence. Some of these include the American Association of Critical-Care Nurses (AACN) Advisory Committee, Health Resources and Service Administration (HRSA), American Medical Association (AMA), WHO Network of Health Promoting Hospitals, American Hospital Association (AHA), and more. The guidelines and standards created by these organizations shape the practices of health care professionals in different ways, but with the same goal of improving care for minorities.

## Training Workshops

Another approach that has been taken to address this issue, is the use of cultural competency workshops. Each can vary in terms of what it includes and what its specific goals are. Multiple researchers suggest that effective workshops should educate providers about the role of cultural factors in influencing the outcome of patient-provider encounters (Khanna et al., 2009). These factors may include, but are not limited to: ethnomedical beliefs and the use of folk medicine, health beliefs, culturally prescribed values and norms, gender-specific status and roles, and religions. Understanding cultural factors allows the provider to better serve their patients. In 2009, a study was performed at Oregon State University, evaluating the outcomes of a specific cultural competency training workshop for health care professionals (Khanna et al., 2009). The workshop lasted 4 hours and focused on both knowledge and skills development. It did so through the incorporation of a traditional lecture component and a skills practice component, where participants would respond to health scenarios. The results of the study indicated that participants experienced a positive shift in their knowledge and skills pertaining to the provision of culturally competent health care (Khanna et al, 2009). This structure, involving both knowledge and skills-based training, may prove to be a good model for future training programs.

## Additional Approaches

Although training workshops can be an effective way to educate health care professionals on culturally competent health care, they are not the only option. At Advocate Lutheran General Hospital, one of the largest hospitals in the Chicago area, education on the importance and implications of cultural competence was added to new employee orientations. A diversity group was formed to organize cultural awareness days, which would allow staff to interact with culturally diverse community members. Local ethnic communities were surveyed to determine both potential barriers and opportunities for providing care specifically to the large South Asian population. This survey led to the creation of the first South Asian Cardiovascular Center in the Midwest, which was created to educate, screen, prevent, and treat South Asians for their high risk of cardiac disease (Health Research and Educational Trust, 2013). Another hospital that serves a very diverse population, Lutheran Medical Center in Brooklyn, also offers examples of innovative efforts. A cultural competence department, with a cultural initiatives coordinator and vice president of cultural competence, was created. The facility has multilingual and multicultural staff members, liaisons, and cultural advisory committees that interact directly with diverse community members. Hospital signage and health forms are provided in the five most common languages spoken in the community. Cultural competence training is required for hospital staff and medical residents. A Chinese unit exists to address specific cultural issues for Chinese patients. Both hospitals have shown great success as a result of their efforts (Health Research and Educational Trust, 2013). The intervention methods they developed could potentially be used as models for other hospitals and health care facilities in the future.

**Methodology**

To investigate this topic, a qualitative case study approach was used. This was due to the project being more focused on gathering opinions and beliefs rather than numerical information. A case study was preferred in this situation in order to be as thorough as possible with one facility, rather than simply scratching the surface with multiple. According to Creswell (2012), dealing with a larger number of cases (sites) can become unwieldy and may result in superficial perspectives due to the amount of details reported for each site. A case study approach provides detailed descriptions and analyses that cannot be measured using a quantitative approach.

It was determined that health care professionals would be the most valuable participants for this study. Due to their direct interactions with patients, they can provide the most relevant information regarding cultural competence in health care. The pool of participants was limited to health care providers at one facility in two departments: Family Medicine and Obstetrics and Gynecology. These departments were selected because they would likely be able to provide the most diverse population of patients. Therefore, these providers would likely have more experience with applying cultural competence. To select participants, a letter containing the purpose, description, and expectations of the study was emailed to all health care employees in these two departments at the health care facility. Employees interested in participating in the study responded to a staff member at the facility and their name was recorded. A Qualtrics electronic consent form was then sent out to these individuals in which they consented to participate and be contacted to schedule an interview date and time. They included their contact information and their availability. Participants were then contacted via email and given five different dates and times to schedule an interview. All participants received a copy of their completed consent form. After an interview appointment was confirmed, a reminder email was sent 2-3 days before the interview date including tips to help the interview flow smoothly, interview instructions, and a Skype meeting link.

All interviews were completed virtually during the summer of 2020. In total, 12 interviews were conducted. Participants included: six physicians, two nurse midwives, one nurse practitioner, and three nurses. Five of these employees were within the Family Medicine department and seven were within Obstetrics and Gynecology.

The main interview questions that were asked are listed in Appendix B. These questions were semi-structured and open-ended, allowing participants to take their own direction, as encouraged by Seidman (2019). All participants were asked several identity questions to ensure that they were identified correctly when results were reported. These responses are shown in Table 1 in Appendix C along with other information about the participants. Other questions examined how health care professionals define and apply cultural competence in their practice. Participants also reflected on their cultural competency training and the availability of resources to improve cultural competence. Additional follow-up questions were asked depending on the topics that were brought up throughout the

interview. The order of the questions did vary between interviews in an attempt to make the conversation flow more smoothly and connect more with each participant. Everyone was offered the opportunity to review the final transcript of the interview to edit, add, or omit anything they wished. Due to COVID-19 and the inability to meet in person, these interviews were conducted via Skype, with two occurring over the phone, and one via Facetime due to technical difficulties. Each interview lasted less than an hour and was one-on-one with the participant. The Olympus Voice Recorder WS-8523 was used to record the audio. Within two days of the interview, the audio file from the interview was uploaded to the online program, Otter.ai. This program roughly transcribed the interview into a document which then underwent manual revisions while listening to the original audio file. Final transcripts were sent back to participants for review within 2-10 days of their interview. Materials collected included notes, recordings, transcripts, and facts about the health care facility and the community that it serves. All of the information that was collected was stored on OneDrive, the University of Wisconsin-Eau Claire's secured data system with two-factor authentication. Participant names were omitted in the final transcripts.

Analysis of the interviews was completed in three phases, with four interviews analyzed at each phase. The interview responses were color coded based on common topics that were discussed during the interview. Those codes were then compiled into a document based on common themes to more effectively analyze the results. Phrases or words that were expressed in two or more of the interviews were highlighted. Highlighted phrases or words from all 12 interviews were then recorded. Relevant phrases that were only present in one or two of the interviews were also recorded. Finally, all 12 interviews were analyzed together and a spreadsheet was created with these common and unique phrases to create a more complete picture of the topic.

**Results**
Each participant shared a unique definition and application of cultural competence as well as descriptions of their previous and current cultural competence training. When interview responses were compared, several commonalities were revealed between participants, but a few key differences were revealed as well. In the charts below, the phrases that were most common among participant responses are towards the top of the chart, decreasing in frequency vertically down the chart. The most common phrases are included in the chart as well as several that were less common, but were necessary and important to have a complete understanding of the topic. The number of participants that used each phrase is on the far right side of each bar. However, these numbers do not indicate that any certain phrase or idea is more important than another.

**Defining Cultural Competence**
Participant responses that were shared in relation to the definition of cultural competence are separated below based on certain themes. However, it is important to note that some participant responses do include more than one theme, creating some overlap.

Participants most frequently defined cultural competence as having cultural knowledge of different beliefs, customs, and values (Fig. 4).

"I think cultural competence means at least to have some basic knowledge of different cultures…" (Participant 1, personal communication, July 14, 2020).

"It's being able to recognize the differences between the different cultural backgrounds with different populations of patients that we see" (Participant 2, personal communication, July 15, 2020).

"Cultural competence... is knowing about a culture's way of speaking, their customs, their ways of doing things, routine, appropriateness, inappropriateness, things such as touch, talk" (Participant 5, personal communication, August 6, 2020).

"An understanding of different cultural needs and outlooks" (Participant 9, personal communication, August 13, 2020).

Some participants defined cultural competence more in terms of being culturally aware and recognizing that other cultures will differ from their own.

"I think cultural competence is just being aware and respectful of other cultures, that not everyone has the same upbringing and the same thoughts and feelings that you have, and so just that concept that you're not always right" (Participant 7, personal communication, August 11, 2020).

"I would say that that [cultural competence] is the understanding that people come from different places in the world and due to that they have different exposures that may lead to them having thoughts, beliefs, or ideas that you aren't familiar with" (Participant 11, personal communication, August 19, 2020).

"I would say that cultural competency lies in the awareness that there are a lot of different cultural perspectives and values and beliefs that are going to differ from mine" (Participant 12, personal communication, August 20, 2020).

Participants mentioned that it requires an active effort, an open mind, and a desire to learn about various cultures.

"...but to also be willing to keep learning from people, whether it be patients or friends or just anybody in the community" (Participant 1, personal communication, July 14, 2020).

"You have to research different things so that you're more on top of this" (Participant 5, personal communication, August 6, 2020).

"I guess the way I've always looked at it as trying to be open and just willing to learn about where other people are coming from because I've learned you cannot assume at all..." (Participant 6, personal communication, August 10, 2020).

"I guess first to understand different cultures and that people function differently in different cultures, and with that understanding, then being able to communicate and interact in a way that is, first of all, respectful, and secondly, even embracing or from a desire to learn" (Participant 8, personal communication, August 12, 2020).

"And that does require me to be eager to learn about different cultures and just be aware that people may have different values and beliefs that are impacting their care and that it's important for me to also be aware of these things and to be actively learning and engaging as well...I think much of that is experience, but we probably also have to go out of our way to educate ourselves on different cultures, knowing that we might not have a lot of interaction to learn just through experience that way" (Participant 12, personal communication, August 20, 2020).

Several participants expressed that cultural competence is an ongoing process and that one cannot ever be completely culturally competent.

"It's more than obviously knowing you're never going to be an expert in everyone's culture. You're never ever going to be able to understand where everyone is" (Participant 3, personal communication, July 16, 2020).

"…I don't know that you really could be competent in all the cultures" (Participant 6, personal communication, August 10, 2020).

"I think me and people in general tend to think what they do is better so that's been an ongoing learning process, just about living and not just practicing medicine" (Participant 8, personal communication, August 12, 2020).

Participants shared that it involves individualizing care to each patient based on their needs, desires, background, values, practices, etc. which may require changing one's approach.

"And we have to take that into consideration with regard to how their cultural background would affect the conversation itself, decision making, advanced care planning, and even long term care plans for the patient, because that's important. Because different cultures have different ways of dealing with health care issues" (Participant 2, personal communication, July 15, 2020).

"It's being able to talk with a patient, let them know that I'm willing to hear what they need to do and share decision making. It involves being able to know where they're

coming from" (Participant 3, personal communication, July 16, 2020).

"To me cultural competence is the ability to provide good care, and also to be subjective across the lifespan, across gender, cultural, religious backgrounds, that meets that patient's needs" (Participant 4, personal communication, July 22, 2020).

"Cultural competence is a type of intelligence that allows you to anticipate and to change your approach based on the culture of an individual and what their needs are" (Participant 10, personal communication, August 18, 2020).

**Applying Cultural Competence**
In regards to the application of cultural competence, several similar phrases and words were discussed (Fig. 5). However, several unique phrases were expressed as well. Again, the responses are separated based on certain themes that manifested throughout the interviews, but some responses do overlap more than one theme. There also is some repetition in the phrases or words that were used to define cultural competence.

The word "ask" was mentioned in all interviews, referring to the practice of asking patients their preferences, expectations, desires, and concerns, as well as asking if there is a gap in cultural knowledge or understanding. Asking open ended questions can help facilitate communication and develop a deeper connection with patients.

"I think instead of assuming a specific culture, practice, or belief for my patients that I actually ask them. You know, if there were any cultural beliefs or religious beliefs that would impact their care or opinion on any medications or procedures, so I can understand where they're coming from because it may not be something that I know of or share their belief in, so that I can understand what drives them." (Participant 1, personal communication, July 14, 2020).

"I think just to ask is the biggest part. 'What do you need?' 'What can I do to help you?'... (Participant 3, personal communication, July 16, 2020).

"A lot of the stuff that I picked up along the way has just come from asking questions of my patients like, "How do you want to be addressed? Is there anything that makes you uncomfortable? What can I do better?" (Participant 4, personal communication, July 22, 2020).

"I think because of my background working in the cities [Twin Cities] and being exposed to that, I do feel like I am a little bit more sensitive to it when someone is coming from a different background, but understanding that I can't really understand them as myself. I think, again, just trying to be open minded and ask questions." (Participant 6, personal communication, August 10, 2020).

"I make sure and ask permission. That's actually on the entry form is 'Are there any things related to childbirth and children that you would like us to honor?' So I guess just asking, because you can't assume." (Participant 9, personal communication, August 13, 2020).

"I think treating each patient individually and asking open ended questions if you don't understand what you're hearing. I think that also admitting to not only yourself, but the patient, if you feel like you are missing something that is important to them and their care and you think that might be due to a gap in knowledge or a misunderstanding based on their culture." (Participant 11, personal communication, August 19, 2020).

"I do try to ask really open ended questions and really try to learn from patients and also just create that space for them to communicate certain things about their culture that I should be aware of." (Participant 12, personal communication, August 20, 2020).

Several participants also mentioned accepting patients as they are and respecting them as being central to applying cultural competence.

"Just having the respect of being able to use the right pronouns and call them by their preferred name and be able to ask them what they need." (Participant 3, personal communication, July 16, 2020).

"I think getting the word out and being supportive.." (Participant 4, personal communication, July 22, 2020).

"You have to treat everybody well and you have to do your best to give everyone the right care.." (Participant 10, personal communication, August 18, 2020).

A focus on social determinants of health, such as social and economic factors, was mentioned as important to fully understand patients and where they are coming from.

"There are people who have a very good support system. That they do manage better, even if they have challenges." (Participant 2, personal communication, July 15, 2020).

"Cause sometimes there's something else that we need to help them with to improve the bigger picture," (Participant 2, personal communication, July 15, 2020).

"I think the time the cultural stuff does come up is with social determinants of health." (Participant 6, personal communication, August 10, 2020).

"We definitely were required to do some community projects and definitely looking into areas of health disparities where you start just becoming aware of how certain things like race and ethnicity, or income brackets, and all of these things, how that affects people's health as well." (Participant 12, personal communication, August 20, 2020).

Similar to the definition of cultural competence, having care be individualized to the patient was expressed as a way to apply cultural competence.

"Everybody is not the same so I think that forming a cookie-cutter approach doesn't work and that you have to understand where they're coming from, so we can tailor our response or our treatment or the way we approach something to them." (Participant 1, personal communication, July 14, 2020).

"...but the right care for one individual may be different from another individual based on their cultural perceptions and their history. Like I said, it's not something that happens in isolation." (Participant 10, personal communication, August 18, 2020).

Many participants shared that staff collaboration was utilized to ensure that all patients were receiving quality, culturally competent care. This collaboration is often effective because staff diversity within the department can provide helpful knowledge and varied perspectives.

"When we were there, we had faculty and staff and nurses who actually are from the same background so that's how we learned. They would give you feedback of how it is, or maybe how to approach." (Participant 2, personal communication, July 15, 2020)

"Honestly, our department's pretty diverse compared to most departments… I feel like it's at the forefront and we do have more of those conversations." (Participant 3, personal communication, July 16, 2020).

"I think a lot of times we just look to each other too. We talk about cases, if there's been any misunderstandings or things that could have gone better. We'll talk as a group and do a peer review." (Participant 4, personal communication, July 22, 2020).

"There was a lot of diversity at the clinic but affluent diversity. So other residents and learners that came from different backgrounds, but not economic issues for them." (Participant 6, personal communication, August 10, 2020).

"I think there are ways to do it, like having your coworkers tell you what their experience and their knowledge is." (Participant 8, personal communication, August 12, 2020).

"I think when we give report if there's a cultural issue, we make sure that the next person coming on knows." (Participant 9, personal communication, August 13, 2020).

"I also know that this is a really safe place to work as far as calling up someone and picking up the phone and saying, 'I had this interaction with this type of patient and it didn't work, and I'm not sure why, but I know that you have experience. Can you help me understand? That is expected here.'" (Participant 11, personal communication, August 19, 2020).

Less common phrases that were used included: "active", "don't assume", "self awareness of biases", "ongoing process", "desire to learn and understand", and "eliminating power dynamics". Participants explained that being self-aware of one's own biases and eliminating power dynamics are both essential in this process. Both of these aspects allow each provider to understand where they are in relation to patients and also helps to develop a better provider-patient relationship.

"I think we can always improve on the way we communicate to patients. Like I was saying before, I'm going to think cultural competency is this ongoing process and not something of like, Yes, I studied it. I did the trainings and I arrived. I think that it does require ongoing focus and especially in people who are not actively working with people from different cultures on a regular basis." (Participant 12, personal communication, August 20, 2020).

"Cultural competence isn't necessarily a one way street either because you have to be aware of your own biases going in." (Participant 10, personal communication, August 18, 2020).

"...and not having a hierarchical way of dealing with patients…You have to be at their level...Having them know that they are in charge of their health care is a prime reason to even become a midwife...Nothing in my job description makes me higher than them." (Participant 3, personal communication, July 16, 2020).

## Cultural Competence Training

### Prior to Employment
Participants were asked about the cultural competence training they had received prior to employment (Fig. 6). All 12 participants expressed that they had this training embedded in their medical school or nursing school classes. Information provided in these classes usually included the following: brief knowledge of cultural customs and practices, different religious beliefs in relation to health care, tips on how to be inquisitive, empathetic, and sensitive, the role of a provider, the soft skills of interacting with others, and how to handle difficult patients. Many participants indicated that this information was simply incorporated into classes, but there was never a formal training on diversity or cultural competence. Therefore, several participants expressed that they were not impressed with this training while in school and believed other training methods were more helpful and effective. Participants commonly expressed that they received cultural competence training from their personal experiences, citing their childhood and personal travel as sources of this training. Growing up in diverse communities helped these individuals become more comfortable with cultures different from their own by gaining  exposure early on in their lives. Additionally, personal travel to other states and countries helped these individuals gain experience with different religions, attitudes, and cultural knowledge, such as dress and gestures. They also expressed that it changed

their worldview and helped them "take their blinders off" and engage with other people. In addition to personal travel, many participants did study abroad in countries including South Africa, India, and Mexico during their undergraduate careers, which again allowed them to gain more exposure to other cultures, step out of their comfort zone, and get a new perspective. Finally, while in medical school or nursing school, several participants went on home-visits, which involved traveling to the patient's home to provide care. Home visits gave providers helpful insight into a patient's lifestyle, values, and beliefs, resulting in a more holistic view of their patients.

**On the Job Training**
Participants were also asked about training they received while on the job (Fig. 7). Many mentioned the Computer Based Trainings (CBTs) that are required quarterly by their facility. These online modules do cover cultural competence, but 6 of the 9 individuals who mentioned CBTs expressed that they were ineffective and very brief. The other 3 individuals mentioned that these modules were helpful to serve as a reminder, but still preferred alternative methods. A few participants mentioned the onboarding process, or employee orientation, as a source of on-the-job training, These individuals shared that the cultural competence information presented in this employee orientation was also brief and ineffective. Alternative methods of training that were described included seminars, classes, and grand rounds, which involve discussions and dialogue between providers. These often involve presentations from health experts, public health officials, or guest speakers who can speak about the cultural needs in the area. All 7 of the participants that mentioned these alternative methods described them as effective in providing a better understanding of these topics and prepared them to provide culturally competent care. Overall, participants expressed that training involving dialogue and discussion was preferred and more effective. Conversational training methods allow providers to keep communication open and provide the opportunity to share ideas and experiences as well as get questions answered. They also help expose participants to ideas they might not normally consider. Hearing patient accounts and going through case studies and examples was also expressed to be helpful. Finally, previous work experience with diverse individuals was noted to be effective in providing cultural competence training. Past experiences exposed individuals to diverse populations, and therefore, increased their confidence and comfort with those populations.

**Cultural Competence Resources**
Participants were questioned about what resources were available to them and which ones they used to provide culturally competent care (Fig. 8). Eleven of the participants mentioned that they had access to language services. These include in-person interpreters, interpreters accessed via phone or video, and patient education handouts in various languages. Some of the individuals who mentioned language services also expressed that although all of these options are readily available, they preferred in-person interpreters. In-person interpreters can provide a more personalized experience and often provide cultural awareness and knowledge as well. Several participants mentioned
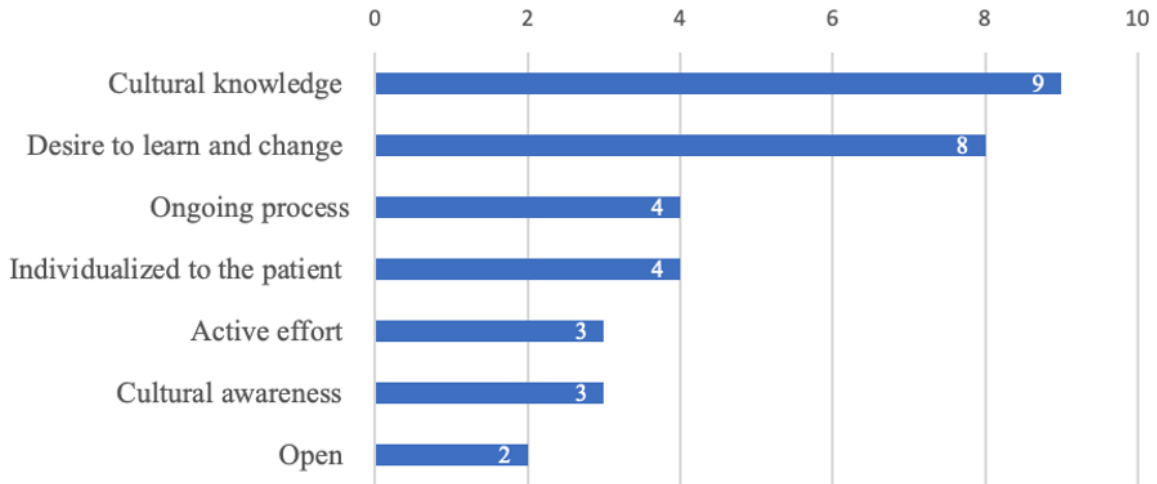
## Definition of Cultural Competence

| Category | Value |
|---|---|
| Cultural knowledge | 9 |
| Desire to learn and change | 8 |
| Ongoing process | 4 |
| Individualized to the patient | 4 |
| Active effort | 3 |
| Cultural awareness | 3 |
| Open | 2 |

*Figure 4:* Participant responses regarding the definition of cultural competence.

## Application of Cultural Competence

| Category | Value |
|---|---|
| Ask | 12 |
| Acceptance | 7 |
| Focus on SDOH | 6 |
| Individualized | 5 |
| Staff collaboration | 5 |
| Active | 4 |
| Don't assume | 3 |
| Self awareness of biases | 3 |
| Ongoing process | 2 |
| Desire to learn and understand | 2 |
| Eliminating power dynamics | 2 |
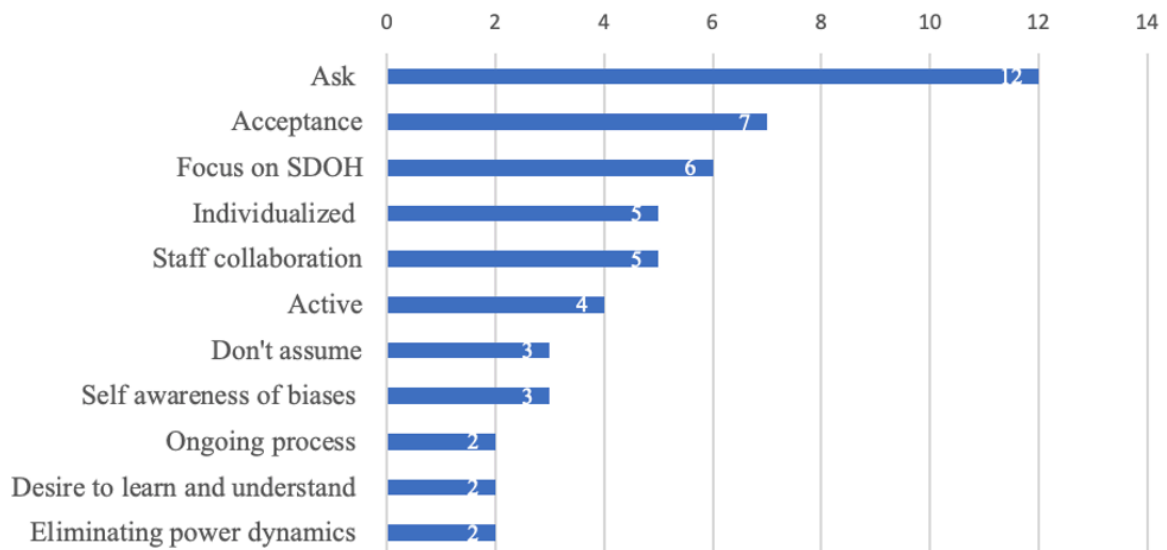
*Figure 5*: Participant responses regarding the application of cultural competence.

## Prior to Employment

Embedded in med school/nursing school — 12
Personal experiences — 7
Study Abroad — 5
Home-visits — 2
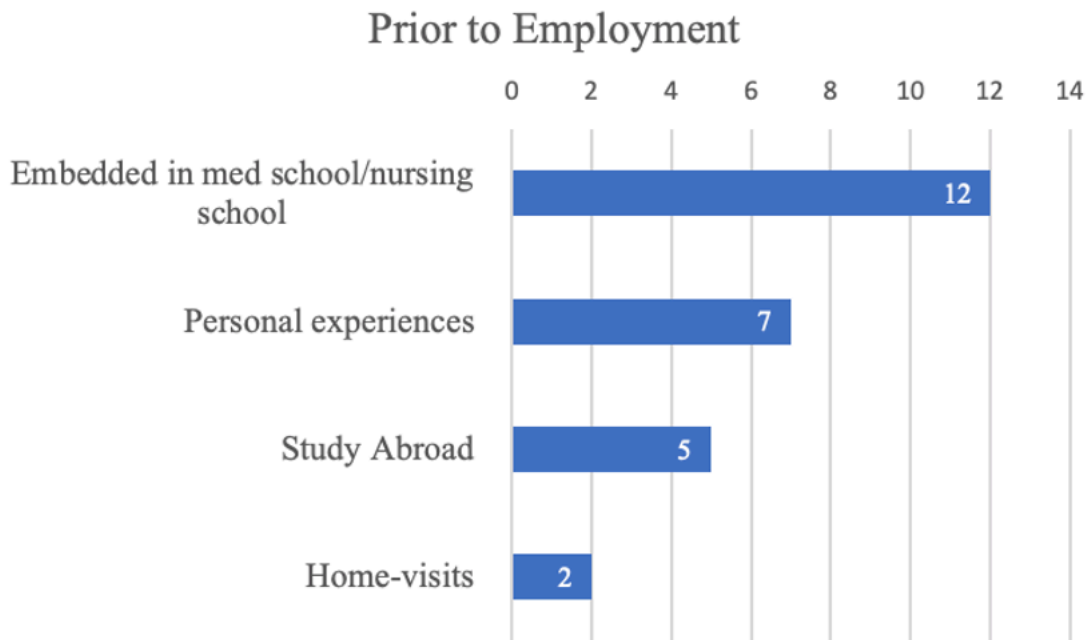
*Figure 6:* Participant responses regarding training received prior to employment

## On-the-Job

CBTs — 9
Seminars/classes/grand rounds — 7
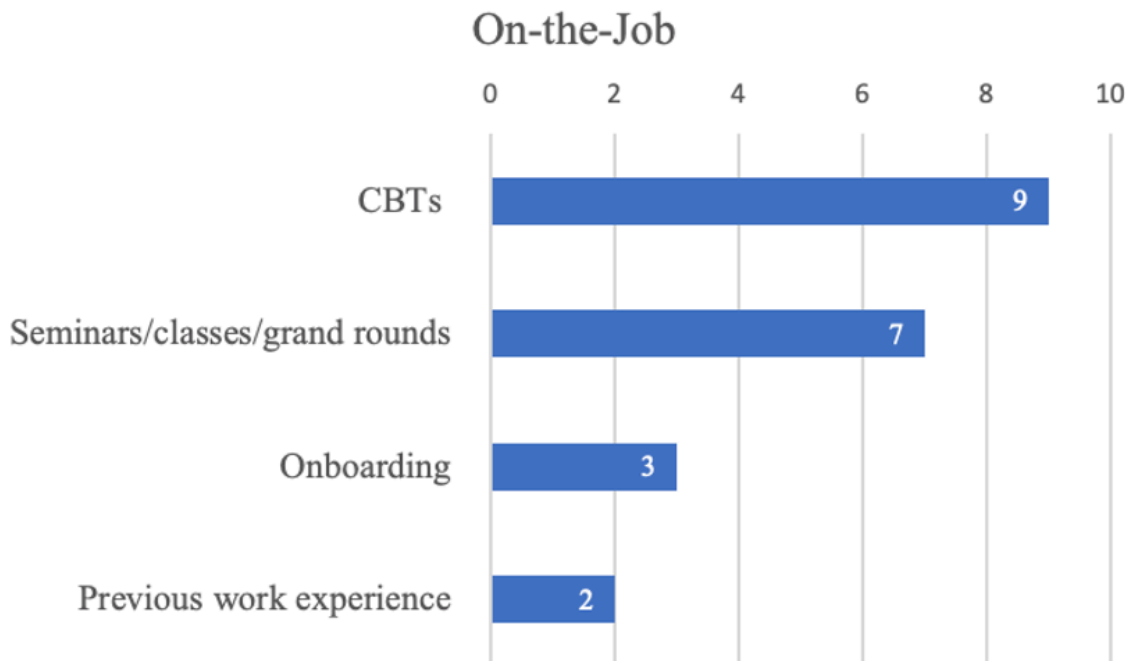Onboarding — 3
Previous work experience — 2

*Figure 7*: Participant responses regarding on-the-job training they have received.

the Diversity and Inclusion group that this facility has as a cultural competence resource. This group is made up of a variety of staff members and is involved in community outreach, community collaboration, and organizes staff education opportunities. One of these opportunities is the critical conversation dialogue series, which has been very successful. These are workshops that cover different topics related to equity, diversity, and inclusion and involve both lecture and discussion components. Participants noted that another way to access cultural competence information is to sign up for additional classes, CBTs, and seminars. Several mentioned seeking out information in scientific journals and articles, the in-house library, and online resources. One individual specifically mentioned the national guidelines and the facility's own guidelines that help to ensure consistent care.

## Discussion

As expected, all participants defined and applied cultural competence in different ways. There were many commonalities between their definitions and the ways in which they applied cultural competence, but there also were differences. These differences are likely due to the fact that each participant has their own background, beliefs, values, and experiences. All of those differences will shape their understanding and application of cultural competence.

## Adherence to Theories

Further analysis revealed certain theories of cultural competence were expressed in the participants' answers. To begin with, many of the participants included cultural awareness and cultural knowledge in their definitions, similar to the definition provided



*Figure 8*: Participant responses regarding cultural competence resources available to them.

by Betancourt et. al (2002). Betancourt's categories of culturally competent methods (organizational, structural, and clinical) were also expressed. Organizational methods present at this facility include the diversity within each department and the training sessions provided by the organization. Structural methods include considering one's own biases and eliminating power dynamics that may serve as barriers for culturally competent care. Clinical methods include communication and tailoring care based on individual needs. The idea that cultural competence involves appreciating and valuing holistic perspectives and is an ongoing, multistep process, as expressed by Spector (2017), was also shared by participants. Leininger's Culture Care Theory was echoed by several participants who noted the importance of considering the interrelationships between care and culture, and what effects that consideration can have on the quality of care provided. The various pieces of the provider level (cultural diversity, cultural awareness, cultural sensitivity, and cultural competence) shown in the 3D Puzzle Model, were all represented in participants' responses in some way. Participants stressed the importance of individualized care, which was expressed by the theory of Culturally Congruent Care. This is due to the fact that even within certain cultural groups, there is variability in beliefs, values, and practices. Additionally, the idea that these constructs are all interconnected and exist nonlinearly was shared between this theory and participants' responses. Finally, the importance of self awareness and identifying one's own biases, expressed by Kersey-Matusiak (2013), was mentioned by a few participants.

**Areas for Potential Improvement**
Through analysis, several areas for potential improvement were identified. These include the CBTs and onboarding process, evaluations of current culturally competent methods, transgender education, access to in-person interpreters, and patient evaluations.

Many participants expressed that the CBTs and employee orientation provided minimal information. They also shared that they were not effective in providing helpful education of cultural competence. These participants preferred more group discussions that included dialogue and/or guest speakers from the community. Trainings like these could be implemented in conjunction with the existing methods or in place of them. Additionally, all participants were unaware of any assessments or evaluations of the current culturally competent methods being used. This would be an area of further investigation, and if necessary, it could be discussed how these evaluations would be completed. Four participants expressed that transgender education was lacking. They felt they lacked the resources to support transgender individuals effectively, making this a potential topic to focus on in training and provide more resources on. In relation to the language services, three participants preferred in-person interpreters. If possible, more in-person interpreters could be made available on site for patients. Finally, it was suggested by two of the participants that more patient evaluations be sent out, specifically regarding the cultural competence of providers. This would help to reveal any deficiencies in the care that is being provided and would lead to further growth and improvement. Correcting any issues that exist could lead to the reduction of health care disparities.

## Conclusion

Although this study only focused on one health care facility and had a limited number of participants, a great deal of helpful information was still revealed. These findings will be shared with the facility the participants work at. Suggestions for possible improvements, which were formulated by critically assessing interview responses, will also be shared. If possible, these suggestions will be utilized to develop plans to improve staff's ability to provide culturally competent care. Finally, there is also the potential to extend this study or to suggest a similar study to other facilities in the area. Doing so would allow for a greater understanding of cultural competence in health care. It also could lead to improvements in the methods currently used with the end goal of decreasing health care disparities.

**Appendix A**

National Standards for Culturally and Linguistically
Appropriate Services (CLAS) in Health and Health Care

**Principal Standard:**

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

**Governance, Leadership, and Workforce:**

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

**Communication and Language Assistance:**

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

**Engagement, Continuous Improvement, and Accountability:**

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

**Appendix B**
Semi-Structured Interview Questions

**Introduction**
Could you tell me a little about yourself?
How did you decide to pursue a career in health care?
How long have you been working at this facility?
What is your position and what are some of your responsibilities in that role?
How do you identify? What is your race? What is your ethnicity? What is your sex?
What are your pronouns? (e.g., she/her/hers, him/his/he, they/them/their)

**Cultural Competence Understanding and Application**
What is cultural competence?  How would you define it?
How do you apply cultural competence in the workplace?
What does cultural competence look like in your current unit/department?
What cultural competency training did you receive both prior to your employment and since you have been employed?
How effective was that in preparing you to provide culturally competent care?
How do staff develop and maintain their cultural competency? What methods (materials, training programs, guidelines, etc.) are currently being used at this location to improve cultural competence among staff members?
Have these methods and services been assessed in the past? If so, please provide examples and/or results that you may be aware of.

**Closing**
Would you like to be contacted to review the transcription of the interview?
Would you like to receive a copy of the final paper discussing the findings?
Are there any other questions that you have for me regarding this research?

**Appendix C**

Table 1: Participant Demographics

| | | | Time at | Race | Ethnicity | Sex | Pronouns |
|---|---|---|---|---|---|---|---|
| 1 | P | FM | 3 yrs | Asian | Indian | F | She/her/hers |
| 2 | P | FM | -* | Asian | Filipino | F | She/her/hers |
| 3 | NM | OBGYN | -* | White | Irish/Swedish/Scottish, Non-Hispanic | F | She/her/hers |
| 4 | NP | OBGYN | -* | White | Western European | F | She/her/hers |
| 5 | N | FM | -* | White | American | F | She/her/hers |
| 6 | NP | FM | 7 yrs | White | American (Belgian, German, French) | F | She/her/hers |
| 7 | N | OBGYN | 4.5 yrs | White | Non-Hispanic | F | She/her/hers |
| 8 | P | OBGYN | 3 yrs | White | Northern European | F | She/her/hers |
| 9 | NP | OBGYN | 4 yrs | White | Non-Hispanic | F | She/her/hers |
| 10 | N | OBGYN | 1 yr | White | Non-Hispanic | F | She/her/hers |
| 11 | P | FM | -* | White | German | M | He/him/his |
| 12 | NM | OBGYN | 9 yrs | White | Non-Hispanic | F | She/her/hers |

*- indicates that time at facility was not mentioned in the interview

Table 2: Key for Table 1

| Position | Department | Sex |
|---|---|---|
| P=Physician | FM=Family Medicine | F=Female |
| NP=Nurse Practitioner | OBGYN=Obstetrics and Gynecology | M=Male |
| NM=Nurse Midwife | | |
| N=Nurse | | |

## References

Anderson, L. M., Scrimshaw S. C., Fullilove M. T., Fielding J. E., Normand J., & the Task Force on Community Preventive Services. (2003). Culturally competent healthcare systems: A systematic review. American Journal of Preventive Medicine, 24(3), 68-79.

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). Cultural competence in health care: Emerging frameworks and practical approaches. New York, NY: The Commonwealth Fund.

Collins, K. S., Hughes, D. L., Doty, M. M., Ives, B. L., Edwards, J. N., & Tenney, K. (2002). Diverse communities, common concerns: Assessing health care quality for minority Americans. New York, NY: The Commonwealth Fund.

Creswell, J. W. (2012). Educational Research: Planning, Conducting, and Evaluating Quantitative and Qualitative Research. (4th ed.). Boston, MA:Pearson Education, Inc.

Health Research & Educational Trust. (2013). Becoming a culturally competent health care organization. Chicago, IL: Health Research & Educational Trust. Retrieved from www.hpoe.org.

Kersey-Matusiak, G. (2013). Delivering culturally competent nursing care. New York, NY: Springer Publishing Company.

Khanna, S., Cheyney, M., & Engle, M. (2009). Cultural competency in health care: Evaluating the outcomes of a cultural competency training among health care professionals. Journal of the National Medical Association,101(9), 886-892

Leininger, M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. Journal of Transcultural Nursing, 13(3), 189-192.

Leininger, M. M. (1991). Culture care diversity & universality: A theory of nursing. New York: National League for Nursing.

Leininger, M. M., & McFarland, M. (2002). Transcultural nursing: Concepts, theories, research and practice. New York: McGraw-Hill.

Schim S. M., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care: Putting the puzzle together. Journal of Transcultural Nursing, 18(2), 103-110.

Seidman, I. (2019). Interviewing as qualitative research: A guide for researchers in education and the social sciences. Teachers College Press.

Spector, R. E. (2017). Cultural diversity in health and illness (9th ed.). New York, NY: Pearson Education, Inc.

U.S. Department of Health and Human Services. (2013). The national CLAS standards. Washington DC: U.S. Department of Health and Human Services.

Yen, H. (2013, June 13). US whites falling to minority in under-5 age group. The San Diego Union-Tribune. Retrieved November 18, 2020 from https://www.sandiegouniontribune.com/sdut-us-whites-falling-to-minority-in-under-5-age-group-2013jun13-story.html