

Does Cultural Competency Training Matter to Health Care Providers: Are We Ready for Mandatory Training?

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Abstract

This study examined 63 healthcare providers (HCPs) receptiveness towards cultural sensitivity training (CST), the amount of this in-service received, and their perception regarding the usefulness of this training for their job performance. Participants in the study were medical staff, nurses and other HCPs from an emergency department in a Long Island hospital. A six point Likert scale questionnaire was administered to assess the receptiveness to CST. Healthcare providers reported levels of agreement varying from 58% to 76% regarding the usefulness of the CST received. The results of the amount of training not received showed a remarkable 70% to 94% of medical staff, nurses 37% to 59%, and 65% to 77% of other HCPs however, HCPs reported usefulness of CST for job performance. In addition, a cross-tabulation was conducted on the ethnicity of the HCPs which showed a lack of diversity. The result of this study confirmed findings in the literature that indicated the need for reduction of health disparities among minorities, and the dire need for culturally competent HCPs and increased ethnic diversity of healthcare professionals.

Keywords: Health disparities, ethnic diversity, healthcare providers' perceptions and cultural sensitivity .

Introduction

The urgency to reduce and eliminate health disparities among minorities has become one of the major goals of healthcare agencies within the United States. Despite the advances in medicine and healthcare, there are still reports of health disparities among ethnic and racial minority groups, based on complex reasons, such as poor patient- provider relationship and the lack of culturally competent HCPs). "Minority patients have been shown to delay seeking care as a result of perceiving cultural insensitivity, observing that their racial group receives a lower quality of care" (Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003 p. 138). One of the major goals of Healthy People 2010 is the elimination of health disparities by the year 2010" (Carter, Lewis, Sbrocco, Tanenbaum, Oswald, Sykara, Williams, & Lauren, 2006).

The continued increase in diversity of the population, and evidence of health disparities facing the healthcare system, indicates great urgency for cultural competence training of all HCPs. Additionally, there must be purposeful effort to bridge the gap in health disparities among the minority patient population. The U.S. Census Bureau of 1996, projected that minority Americans will comprise 40% of the U.S. population by the year 2035 and 47 % by year 2050 (Brach, & Fraser, 2000). The Census Bureau of 2002, projected that by year 2050 the population of non-Hispanic Whites will decrease from 71% to 53% (Crosson, Deng, Brazeau, Boyd, & Soto-Green, 2004).

Research literature and studies indicate a universal need for culturally competent health care providers (HCPs) to improve healthcare outcomes, with the goals to provide high quality healthcare to all minorities. According to Betancourt, Green, Carrillo and Park (2005) "The goal of cultural competence is to create a health care system and workforce that is capable of delivering the highest-quality care to every patient, regardless of race, color, ethnicity, or language proficiency" (p. 499).

Delivering high quality health care and providing equal and fair access for all patient population continues to be investigated at multiple levels within healthcare organizations. The National Institute of Health (NIH), Joint Commission on the Accreditation of Healthcare Organizations (JCAHCO), the National Committee for Quality Assurance, Institute of Medicine (IOM), and the American Academy of Family Physicians (AAFP) are supporters of this initiative. The Federal government, a major purchaser of healthcare, also plays a critical role in assuring that all healthcare agencies complies with Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on race, color or national origin (Carter, et al., 2006).

Public awareness of the racial and ethnic disparities was increased by the Department of Health and Human Services and the Office of Minority Health 2001 report. The results of the Culturally and Linguistically Appropriate Services (CLAS) report led to the first set of comprehensive and nationally recognized set of standards for cultural and linguistic competence in healthcare settings. These standards were specifically developed for hospitals, clinics

and other outpatient settings, and are also recommended for utilization in private physicians' offices. This report identified and recommended numerous interventions to improve cultural competence among HCPs. The underlying premise of CLAS is to effect changes in health disparities through the elimination of cultural and linguistic biases. The acknowledgment that cultural competence in cross cultural communication is a necessary skill for HCPs is evident throughout the literature. The use of this skill has shown improvement in establishment of accurate assessment, diagnosis, treatment plan, effective interview, and improved access to care for minorities (Misra-Hebert, 2003; Cooper, L., Hill, M., & Powe, N., 2002).

Mandating cultural competency for physicians, has been part of the legislation signed by New Jersey Acting Governor Richard Codey, while legislators in Arizona, Illinois and New York are considering similar Bills. The legislative Bill in New Jersey has now left the State Board Medical Examiners to institute law that formalize CPT inclusive of the amount of training necessary for increased professionalism and humanism in medicine. The requirement for CCT has become a part of the curriculum of medical schools, with changes taking place in the medical schools and residency programs (Pelletier, 2005).

Several studies have shown that when patients share a racial or ethnic background with their healthcare provider, there is a significant racial concordance that leads to high patient satisfaction (ACP, 2004). The 2006 National Healthcare Disparities report found that barriers such as communication problems between patients and their HCPs have been noted as one of the growing problems of health disparities (Smedley, 2008). According to the bureau of Health professions (2002) representation of African American/Black and Latino groups of registered nurses, remains far less than the general population. Although African American nurses represent the largest group of minority nurses, they are still significantly underrepresented. The Hispanic population has shown the largest increase in growth however, only two percent of Hispanics are represented in the nursing profession.

Purpose of the Study

This study examines HCPs perceptions regarding the need for cultural competency training and the amount of in-service training HCPs received in cultural sensitivity, interpretative services, and cultural diversity. The study also explored the ethnicity of the HCPs.

Perspective(s) or theoretical framework

Although the terms culturally sensitive and cultural competent have been used interchangeable throughout the literature, there are few researchers who are able to concisely define the differences between these terms (Tucker, Herman, Pedersen, Highley, Montrichard & Ivery, 2003). To be culturally competent is to understand the meaning and the history behind cultures. According to Banks (2005), there are many different definitions for culture and no single definition is accepted by all social scientists. Culture is the central existence to human nature; therefore, it is imperative that healthcare workers be culturally knowledgeable and competent to respond to the health needs of patients served. It is crucial that healthcare providers possess tools necessary to obtain information, communicate, and understand patients' health needs (Bonder, Martin, & Miracle, 2001). Mattson (2000) states, "In our pluralistic society, health care providers must be prepared to work with all clients regardless of cultural background and to provide care that is as culturally competent as possible" (p.1). Horner et al., (2004) states the concept of cultural competence includes self awareness, understanding of culture, and sensitivity to cultural issues of individuals.

Purnell and Paulanka (2003) referred to cultural competence as self awareness of one's existence, sensations, thoughts, and environment without bias or prejudice. To be culturally competent is more than an understanding of race and ethnicity. Cultural competence is a higher level of knowledge in the care designed to meet the needs of marginal groups, individuals and communities of people different from the mainstream society (Giger, Davidhizar, Purnell, Harden Phillips & Strickland, 2007). Cross, Bazron, Dennis and Issacc (1989) stated that a culturally competent system of care is defined as: (a) valuing diversity (b) having the capacity for cultural self assessment (c) being conscious of the dynamics inherent when cultures interact (d) institutionalized cultural knowledge (e) developed adaptation of service delivery, reflecting, and understanding of cultural diversity.

In the study 'Evaluating the Effects of Cultural Competency Training on Medical Student Attitudes' two curricular methods contributed to an improvement in attitudes towards assessing patients' health beliefs. The result of the study showed that the female medical students were more likely to see the value of knowing the patient's perspective for providing good healthcare. Although the study did not find a significant change in the students self reported attitude, there was improvement in attitudes towards the assessment of patients' health beliefs (Crosson, Deng, Brazeau, Boyd, & Soto-Green, 2004).

The study, 'Cultural Competency Training for Third Year Clerkship Students; Effects of an Interactive Workshop on Students Attitudes' found that workshop, improved third year medical students attitudes, beliefs and

cross-cultural communication skills. The results showed that most of the participants agreed that the cultural competence course offered was appropriate and effective. While the overall cultural attitudes were positively affected, the study also emphasized that a short course was beneficial for participants (Carter, Lewis, Sbrocco, Tanenbaum, Oswald, Sykora, Williams, & Hill, 2006).

A descriptive exploratory study examining cultural awareness of public health nurses perceptions regarding working with diverse patients' revealed that the nurses rated themselves as ranging from somewhat to very culturally competent. This study explored the nurses own cultural sensitivity and awareness, training in cultural competence and difficulty experienced with culturally competent care. The nurses expressed a desire for additional cultural competence and diversity training in order to better service patients (Starr, & Wallace, 2009). The need for cultural assessment in the healthcare setting is an important component of the patient's health history. In fact, if cultural behaviors aren't appropriately identified, their significance can be confusing to health care providers and can be potentially alienating to the client. A cultural assessment elicits shared beliefs, values, and customs that affect all aspects of health (Mattson, 2000).

Descriptions of participants

The participants in this study were limited to 63 HCPs. Data was taken from a large dissertation study by Degois (2005). The subjects were categorized as medical staff, nurses and other HCPs employed at a Long Island hospital, emergency department. There were a total of 11 (18%) White medical staff, 27 (43%) White nurses and nine (14%) White other healthcare staff. The total number of Black/African American medical staff was one. Black/African American nurses were six (10%), and three (5%) other healthcare staff. The number of Hispanics/Latinos medical staff was zero; one Hispanic/Latino nurse, and a total of five (8%) other Hispanic/Latino healthcare staff. Forty (63%) respondents were female, and 23 (37%) were males. Total HCP experience ranged from 1 to 35 years, with an average of 11 years.

For this study a cross-tabulation (table 1) was conducted of HCPs ethnicity revealing that most HCPs were White/Caucasians 47(75%), 10 (16%) were Black/African American and 6 (10%) were Hispanics/Latinos. Eighty five percent of the medical staff was United States citizens, the other 15% were from other countries. The remaining group originated from Aruba, Dominica, England, Guam, Nigeria, Pakistan, Philippines, South Africa and Trinidad.

The chi-square analysis showed a relationship between ethnicity and HCPs attitude towards Cultural sensitivity training.

Table 1

Cross-tabulation Between Ethnicity with the Health Care Staff

			Medical Staff	Nurse	Other	Total
Ethnicity	White/Caucasian	Count	11	27	9	47
		% of Total	17.5%	42.9%	14.3%	74.6%
	Black/African American	Count	1	6	3	10
		% of Total	1.6%	9.5%	4.8%	15.9%
	Hispanic/Latino	Count	0	1	5	6
		% of Total	.0%	1.6%	7.9%	9.5%
Total		Count	12	34	17	63
		% of Total	19.0%	54.0%	27.0%	100.0%

Medical Staff= Doctors and Physician Assistants; Nurses; Other Staff= Certified nurse aides. Xray tech, lab technicians, radiologist, social worker.

Methodology

Descriptive statistic analysis was conducted to evaluate the HCPs responses regarding CST and amount of in-service training. The questions examined cultural sensitivity with limited English patients (LEP), use of interpretation services and CST for diverse population.

Research question one: Whether HCPs believe that their training on cultural sensitive with LEP, use of interpretation, and customer services for diverse population are useful for their job. The number of in-service training HCPs received was measured by a six point Likert scale. The following items are used to measure CST with LEP: For clarity of the paper we maintained the original numbering used in Degois dissertation.

Item 7. My training in cultural sensitivity with limited English will help with my job.

Item 8. My training in use of interpretation services will help with my job.

Item 9. My training in customer service for diverse population will help me with my job.

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Research question two: Amount of in-service received. Participants answered question 10 to 12. They completed a fill in section reporting training sessions ranging from zero to five. Descriptive statistics were applied to this portion of the data.

Item10. How many in-service programs on cultural sensitivity with limited-English-speaking patients have you received?

Item11. How many in-service programs on the use of interpretation services have you received?

Item12. How many in-service programs for diverse patients have you received?

Chi-square analysis was used to examine the relationship between HCPs ethnicity and receptiveness towards cultural sensitivity training.

Results

1. Whether HCPs believe that their training on cultural sensitive with LEP, use of interpretation services, and customer service with diverse population is useful for their job?

Seventy seven percent of medical staff believed that cultural sensitivity training with limited English patients would assist them with their job. Of the nursing staff 83% agreed and 59% of the other Staff HCPs believed that it would help. Findings indicated that 100 % of the medical staff, 83% of nursing staff and 88% of other HCPs agreed that the use of interpretation services would be beneficial. Eighty eight percent of the medical staff believed that training in interpretation services, would facilitate job performance while 78% of nursing staff and 71% of other HCPs also agreed (see Table 3). In addition 17.6% of the medical staff found that CST with LEP was not applicable (NA) to job performance.

Table 3. *Customer Sensitivity Training, Use of Interpretive Services, Diverse population customer service.*

	Medical Staff				Nurse				Staff			
	NA	SD+ D	SLD	A+ SA	NA	SD+ D	SLD	A+ SA	NA	SD+ D	SLD	A+ SA
7.	17.6	5.9	0	76.5	0	14.3	2.9	82.9	17.6	23.6	0	58.8
8.	0	0	0	100	5.6	11.1	0	83.3	11.8	0	0	88.2
9.	5.9	0	5.9	88.3	5.6	11.1	5.6	77.8	17.6	5.9	5.9	70.6

NA=Not applicable, SD= Strongly disagree, D= Disagree, A= Agree. SA= Strongly Agree

2. Amount of in-service training HCPs received.

Table 4 shows that seventy-one percent of medical staff reported no training with LEPs within the last year. Thirty seven percent of the nurses reported no training with this population and 65% of other HCPs also reported no training. The reported training received by participants occurred between 1993 through 2005 and the amount of in-service training ranged between zero to two for medical staff. The total duration of HCPs training ranged from 10 minutes to four days. The amount of training for nurses ranged from zero to four, and hours of training ranged from zero to nine as reported by six out of 23 nurses. Other HCP staff reported a total of zero to three in-service classes.

In-service	Medical Staff							Nurses					Staff					
	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
Cultural Training	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
Q10 Limited English	70.6	12	18	0	0	0	37	37	11	11	2.9	0	65	18	5.9	12	0	0
Q11. Interpretation	65	29	5.9	0	0	0	49	31	11	2.9	2.9	2.9	77	12	12	0	0	0
Q12. Diverse Patients	94	6.2	0	0	0	0	59	21	18	2.9	0	0	69	19	6.2	6.2	0	0

Sixty five percent of medical staff, 49% of nursing, and 77% of other HCPs received no training on the use of interpretation services. Medical staff reported the least amount hours of interpretation services. Amount of training hours ranged from zero to three hours with three out of 18 medical staff responding.

Ninety four percent of medical staff reported zero in-service training for diverse patients, 59% of the nursing staff reported not receiving any training and 69% of other HCPs also reported no training. Sixteen out of 18 (89%) medical staff reported receiving no training for diverse patients. The last training reported ranged from no formal training to 10 years ago. The total duration time ranged from 15 minutes to 2 hours. The results of this study indicated that HCPs received limited interpreter and diversity training services and the HCPs agreed that CST will facilitate job performance.

Discussion

Research literature on cultural competency training for HCPs exposed the great need for universal cultural sensitivity training. This study revealed that despite HCPs perception that cultural sensitivity training would facilitate their job in the emergency department; HCPs do not actually receive this type of training. Culturally sensitivity training is highly recommended for medical staff to ensure quality and parity of health care to all consumers. The institution of mandatory CCT must have Healthcare Organizations providing comprehensive and

formal programs that train and maintain HCPs knowledge and skills to foster effective cultural diverse work environment.

Insufficient CCT maybe the result of HCPs resistance towards emerging mandates. HCPs should have a “better understanding of the different diseases that affect diverse population and of the health-related cultural belief and expectations patients bring to doctors practices” (Pelletier, 2009 p. 2).

The evaluation and need for cultural competency training of HCPs continues to be debatable and problematic for educators in the health care system. The assumption that HCPs individual knowledge and self – confidence are sufficient for change in health disparities continues to be the underlying cause for ineffective healthcare practice (Kumis-Tan, Beagan, Loppie, MacLeod, & Frank, 2007).

In this case study only sixty three respondents participated; the majority (47) identified as White, (10) Black and six Hispanic staff. This disproportionate cultural representation among health care staff is an indication of the larger inequality that exists between health care provider and health care recipient. If disparities between HCPs and patients are to decrease then an increase in sensitivity to the individual needs of culturally diverse groups must be sowed. Mandating cultural sensitivity training may not be met with sincere enthusiasm however, it will provide protection for the underrepresented consumer, ensure parity of health care services, reduce fears of unfamiliarity with increasing multicultural population and increase trust between both doctor and patient.

The results of this study indicated that HCPs received limited training in the use of interpretation service for LEPs. The need for CLAS to decrease communication barriers, between HCPs and patients with limited English proficiency continues to be a cultural skill necessary to improve patients and healthcare providers’ relationship. It is therefore imperative that HCPs be trained in cross-language communication, by learning how to identify the need for interpretative assistance and utilization of such services appropriately. Clear and effective communication between patient and HCPs has been shown throughout the literature as a means in decreasing some of the existing health disparities and increase patient satisfaction. The ancillary goal of this study is to re-enforce the recommendations of accreditation mandates on cultural competency, and the institution of mandatory biannual re-certification training for all HCPs.

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