

A Model Cultural Competency Handbook for Health Care Professionals: Creating an Ideal
Handbook to Reduce Disparities

By

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ABSTRACT

Purpose: The first purpose of this paper is to develop a model that identifies and describes the primary categories that should be included in a cultural competency handbook for health professionals. Second, health care professionals who then provided constructive feedback examined the preliminary model. Lastly, a revised model was developed incorporating the feedback provided by the health care professionals.

Methodology: Focused interviews were conducted with ten professionals within the health care industry to ascertain the soundness of the cultural competency handbook model. All of the interviewees provided open ended responses during their interviews.

Results: The recommendations provided during the interviews were incorporated into the preliminary cultural competency handbook model. As a result, a revised version of the model was developed that included the following additions: Cultural Customs, Historical Perspective, Health Information and Privacy, Creating a Safe Space for LGBT Patients, Screening and Education for LGBT Patients, Translation Guidelines, Recommended Phrasing, Culturally Representative Photography and Font Type.



ABOUT THE AUTHOR

Krystal Gilliam is a Cancer Information Specialist at the American Cancer Society. She has been working for this well respected non-profit organization since September of 2006. Before relocating to the Central Texas area, Krystal was a Research Interviewer for the largest Mexican American health study in the United States. This study was a cohort program at The University of Texas M.D. Anderson Cancer Center in Houston, Texas. Krystal received her Bachelor of Science in Public and Community Health from the University of Houston. Her email is kgillia@gmail.com.

AUTHOR'S NOTE

The idea for this applied research project was inspired by a woman I spoke to only once. However, that one ten minute conversation helped me understand how I could fulfill an important goal in life. That goal is to always be a part of a movement that strives to improve people's lives and to always be a tireless advocate for equality. In my professional life, I have been a research interviewer for the largest Mexican-American health study in the United States. And currently I am an employee at one of the most trusted brands in the country, the American Cancer Society. My role as a Cancer Information Specialist allows me to speak to cancer patients and their loved ones on a daily basis. Every day I get to help make a difference in someone's life during their darkest hour and for that I am very grateful.

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Chapter 1: Introduction

Many health care organizations utilize employee handbooks to discuss policies and other important information that employees may find useful. Company employee handbooks are one of the most important communication tools between a company and its employees. Not only does a handbook describe employee expectations, it also presents what employees can expect from the organization. A handbook is a valuable learning tool health care organizations can use to increase awareness for and a better understanding of traditionally underserved populations.

Health professionals need to be culturally competent to better serve a growing and culturally diverse population within the United States (Anderson et al 2003). As the demographics of our nation continue to change, healthcare organizations should have resources in place to ensure health professionals have the tools to serve and understand all patients (Fernandez et al 2004). These cultural competency resources may come in various forms, like online presentations or in class instruction. But they should all include a supplemental tool such as a cultural competency handbook. A handbook can provide guidance on various topics that pertain to diverse populations to ensure their needs are being met in a thoughtful and respectful manner (Brach 2000). A cultural competency handbook can also help close health disparities¹ between various groups. There is very little information available that discusses what fundamental topics should go inside a cultural competency handbook. Thus, there is a need for a model organization for cultural competency handbooks that encompasses the following topics: cultural competence, cultural sensitivity, mistrust, sexual orientation, communication and handbook design. The literature reviewed for this project identified these six categories as

¹ The Minority Health and Health Disparities Research and Education Act of 2000 describes disparities as differences in “the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates.” Many populations are affected by disparities including racial and ethnic minorities, residents in rural areas, women, children, the elderly, and persons with disabilities.

fundamental topics that should be included in a cultural competency handbook. these topics will be included to serve all populations in an effective manner and help reduce disparities.

Research Purpose

This research examines why a cultural competency handbook would be a valuable tool for health professionals. In a multicultural society a culturally competent health professional should possess a set of skills that enables them to care for culturally diverse patients. The United States Census estimates more than 30% of the total population is made up of non-whites, meaning one out of every three people in the United States can be classified as a person of color². By 2050, half of the population will be comprised of non-whites (Santibanez et al, 2006, 319). As a result many healthcare institutions created programs to help professionals learn how to better serve the needs of diverse populations. These programs vary widely and cover a myriad of topics.

The first purpose of this paper is to describe a preliminary framework of topics that should be included in a cultural competency handbook for health care professionals. This framework includes fundamental categories that should be included in a cultural competency handbook. The categories are: cultural competency, cultural sensitivity, communication, common misconceptions, mistrust and the handbook layout. Second, experts will assess the cultural competency framework and provide useful feedback to improve the framework. Third, based on that feedback a revised framework will be developed. Finally, the new framework will be used to create a cultural competency handbook for healthcare professionals.

Biases, Stereotypes and Their Effect on Minority Health

Minority patients are less likely to participate in clinical trials, have less access to knowledge and specific medical techniques compared to whites heterosexuals. Furthermore,

² See United States Census report for more demographic information by race and ethnicity.

members of disparate groups often have a much lower level of trust toward their care providers (King, 2003, 366). For example, institutionalized racism in health care stemming from experimentation on slaves or the Tuskegee syphilis experiments have caused many within the African American community to have a very low opinion of non-minority health professionals.

Many health professionals believe they treat patients based in a very uniform manner that is void of personal bias and stereotypes. But this is not the case. As noted in one article, when forced to make decisions in fast paced work environments health care professionals may often rely on stereotypes or biased expectations (Perloff et al, 2006, 838). Physicians surveyed in 2000 perceived African American and members of low socioeconomic groups more negatively than they did whites or members of higher socioeconomic classes. Physicians judged a patients' intelligence based on their race (van Ryn & Burke, 2000, 822). Even when actual education levels were adjusted, according to van Ryn and Burke (2000, 822), statistically Whites were more likely to be labeled educated than African Americans. There is evidence some doctors may behave differently with patients from lower socioeconomic groups. Willems et al, (2005, 143) noted doctors provide less information to low-educated patients and inaccurately assume these patients are not interested in receiving information about their health or lack the ability to understand the information. This type of stereotyping and bias against socioeconomic status and/or race can lead to devastating results. People of color are disproportionately effected by these actions.

When dealing with patients who have limited English skills, Diamond et al (2009) found doctors will use a technique called "getting by". Where instead of seeking out a professional interpreter to discuss treatment options, these health care professionals enlisted the assistance of anyone in the area to translate. These individuals could include a patient's family member or

even the janitor at the care facility. In regards to decision-making, most members of minority groups can still make decisions on behalf of their loved ones regardless of socioeconomic status and/or race. However, hospitals can still deny same sex couples from participating in their partner's care decisions (Harcourt, 2006, 4).

Disparities in Healthcare

One of the primary objectives of this research is to raise awareness on how a cultural competency handbook can reduce health disparities in minority populations. Health care disparities exist when members of one social group receives inferior treatments and outcomes when compared to other groups (Balsa & McGuire, 2003, 89). Some of the causes for disparities between populations can be attributed to factors such as lack of insurance, which effects communities of color, especially African Americans and Latinos, more than Whites. Another contributing factor could be lack of transportation which can be a substantial hinderence for people who live in urban areas. However, disparities may still exist when social factors such as transportation or lack of insurance have been ruled out (Zambrana et al 2004). Researchers Balsa and McGuire (2003, 90) noted when insurance and access do not vary black patients may still receive a substandard level of care compared to white patients.

Cultural mismatches between the professionals who provide the care and the patients they are supposed to serve may contribute to the health care disparity in this country (Jones et al, 2004, 283). Racism has also been identified as a factor, contributing to disparities. Gilbert Gee (2002, 615) defines racism as “an oppressive system of racial relations, justified by ideology, in which one racial group benefits from dominating another and defines itself and other through this

domination.” Our society has progressed in this area since the days of Jim Crow³ and the Civil Rights Movement of 1964, but there are still additional barriers to overcome.

People experience and define health and disease through the lens of their own culture (Wachtler and Troein 2003). So it is important health professionals recognize these differences and adapt to them. The literature discussed throughout this paper highlights examples of bias towards different groups of people. A handbook should identify these biases and provide solutions or guidance to health professionals to reduce disparities and improve quality of life. A cultural competency handbook would help close the disparity gap by addressing six areas that deepen the disparity gap.

The Role of Healthcare Professionals⁴

The United States is a melting pot, filled with different languages, cultures, and ethnicities. And most Americans, at some point in their life, come in contact with a health professional. It is important these professionals are culturally competent and are able to meet the needs of patients who are different from themselves with dignity and respect. This can be achieved, according to Anderson et al (2003, 69) a culturally competent healthcare setting should have a mix of the following: a diverse staff, access to translators or resources for non-English speaking patients, along with a culturally specific setting, providers who have knowledge patients culture and their cultural norms.

A forward thinking, progressive healthcare professional must possess “superior communications skills and must be sensitive to the unique needs of each patient” (Capell 2007, 30). In recent years addressing the needs of diverse populations has become a popular topic in health care literature (Diamond 2009) (Surbone 2008) (Rodriguez et al 2008). Models that look

³ A set of laws that deprived African Americans of their civil rights between 1877-1964.

⁴ For more Texas State University Applied Research Projects dealing with health related topics see Blank 2006; Doehrman 2007; Richards 2006; Thorton 2000; Trial 2009.

at health outcomes for diverse populations and medical education curricula have helped the conversation around cultural competency programs. The momentum sparked by this dialogue points to the need for a cultural competency handbook. A handbook can enhance the knowledge base of a health professional by providing them important insights into cultures that are different from their own. Having access to that type of information in the form of a handbook is not only convenient, but can help practitioners and other health care workers avoid uncomfortable and or harmful interactions with patients who come from different cultural groups.

Looking Ahead

This project identifies six key categories that should be included in cultural competency handbooks. Each category explores why these areas are important to health care professionals and why they should be included in a cultural competency handbook. Chapter one, the Introduction, discusses what cultural competency is and a historical perspective that highlights its critical role in disparity reduction. Understanding the causes of these disparities can provide insight into workable solutions to be included in a cultural competency handbook and help close the disparity gap. The purpose of chapter two is to explore the role a cultural competency handbook would play in a healthcare setting and its importance to the field. The third chapter highlights the Preliminary Model which resulted from a review of scholarly literature covering six main categories and their subcategories. Chapter four, the Methodology section, focuses on the interview process and human subjects protection efforts during the project. Specific outcomes and findings from the focused interviews are explored in chapter five, this is also the Results section. The Conclusion, chapter six, presents the revised cultural competency handbook model. This chapter also summarizes the entire Applied Research Project and highlights the limitations of this study and offers suggestions for future research.

Chapter 2: Setting

Chapter Purpose

The purpose of this chapter is to introduce a framework for a cultural competency handbook. The chapter begins with exploring the meaning of cultural competency. Followed by discussion on why culturally competent health care professionals are important; this includes doctors, nurses, social workers and other health care professionals. Next, the chapter would provide information on the benefits of a culturally competency handbook by examining recommendations and legislation from key accrediting bodies and two states that discuss cultural competency policies. The chapter concludes with a discussion on the role of a culturally competency handbook in health care and how it can amend the overall health of disparate populations.

A Culturally Competent Healthcare System

The need for a more culturally competent health care system has been well documented⁵. A study examining cultural issues among resident physicians found 96% of the doctors who participated in the survey felt addressing cultural issues were important to health care. However, 50 % reported they had little or no training caring for patients from different cultural backgrounds. (Weissman et al 2005). In nursing education, caring for diverse populations was not a primary focus until recent years. However, now most professionals overwhelmingly agree that cultural differences is very important to their field, however health care establishments are not consistently providing them with the tools they need to better serve disparate populations.

Cultural competency is a growing and evolving concept that not only applies to the individual, but it is also appealing to organizations also. There are health care institutions investing money and resources to help improve the quality of care for minority populations by

⁵ For more information on studies see Kripalani et al 2006, Ridley et al, 2002 and Suh 2004, and Tucker 2007.

creating cultural competency tools or programs. These establishments recognize the value of having staff members who come from various backgrounds, understand different cultures and speak languages besides English or have access to translators (Surbone 2006). For example The University of Texas M.D. Anderson Cancer Center, a leading cancer treatment and research institute, has an entire department devoted to providing support to cancer patients from various ethnic backgrounds primarily based on language. Health professionals in this department are able to communicate with patients and work closely with care team to help them navigate cultural differences that may be present.

Two states, California and New Jersey, have taken the lead in requiring health professionals seek extensive cultural competency trainings. Both, California and New Jersey have large immigrant populations and a large non-Anglo population. New Jersey requires cultural competency training as a condition of physician licensure (NJ Bill SB144, 2005). While California mandates all continuing medical education courses, unless exempted, to contain curriculum pertaining to cultural and linguistic competence in the practice of medicine (Assembly Bill 1195, 2006). A cultural competency handbook would of course be one of the many techniques healthcare organizations can use to close the disparity gap. A handbook can also speak to an organization's, and in the case of NJ and CA, a state's commitment to social purpose and signal to a willingness to promote better healthcare for all.

On the federal level, two important pieces of legislation have been introduced in the House of Representatives that support reducing health disparities. The Ending LGBT Disparities Act (H.R. 3100) introduced by Rep. Tammy Baldwin of WI addresses disparities in the lesbian, gay, bisexual and transgendered communities and seeks to eliminate the barriers they face when seeking quality health care. H.R. 3100 includes national standards for culturally competent

healthcare, seeks to establish a national center for cultural competency, and would provide grants to institutions to “enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve cultural competence in health”.⁶

The second, and more controversial, legislative effort that addresses cultural competency can be found in the latest bill proposing sweeping healthcare reform in the United States. The Patient Protection and Affordable Care Act (H.R. 3590) includes information to enhance health care professionals’ education by including cultural competency training.⁷ Finally, a cultural competency handbook can provide useful, life saving information to professionals who are unsure or unfamiliar with different cultural groups.

Chapter Summary

Across the health care spectrum, cultural competency is an important topic and increasing knowledge among professionals has become a primary focus of many cultural competency researchers. Leading health care institutions like The University of Texas M.D. Anderson Cancer Center and the American Cancer Society are vamping up their efforts to educate their employees on the benefits of becoming culturally competent professionals. As nonprofits and research institutions work to become more culturally competent, states like California and New Jersey are implementing policies to ensure cultural competency standards are integrated into statewide programs and efforts.

Institutions can create cultural competency training courses, states can create criteria with legislation to make cultural competency education mandatory for health professionals, but a well written handbook can also help those who come in contact with disparate populations. In the next

⁶ See <http://www.opencongress.org/bill/111-h3001/text> to view full text of H.R. 3100 Ending LGBT Health Disparities Act.

⁷ See <http://www.opencongress.org/bill/111-h3590/text?version=ocas> to view full text of H.R. 3590 Patient Protection and Affordable Care Act.

chapter, a preliminary model for a cultural competency handbook is presented and the components in the model are compiled from a range of perspectives. Each component's goal is to reduce disparities, increase awareness among health professionals and improve the quality of health care.

Chapter 3: The Preliminary Model

Chapter Purpose

The purpose of this chapter is to provide a framework for the essential components of a cultural competency handbook. This model is arranged according to a coherent conceptual framework.⁸ A preliminary model for a cultural competency handbook to be used by health care professionals includes six components. The first component discusses cultural competency and the elements within this component discusses various definitions for the term and cultural competency techniques. The second component examines cultural sensitivity and looks at three elements: interpersonal qualities, individualized care, and socioeconomic status. The third component in the preliminary model discusses the mistrust patients from disparate populations may have for health care professionals. This component explores the reasons for mistrust and how health care professionals can understand and overcome this barrier. The fourth component deals with sexual orientation. Understanding how this particular population has been adversely impacted in regards to health by silence is discussed in this section. The fifth component of this preliminary model discusses communication. The elements of this component include language barriers and health literacy. The sixth and final component of this model deals with a cultural competency handbook design. Combined all six of these components represent an initial model for a cultural competency handbook for health care professionals.

Cultural Competency

Terry Cross, et al (1989, 7) defined cultural competency as “a set of congruent behaviors, attitudes, policies and structures that come together in a system or agency or among professionals and enables the system, agency, or professional to work effectively in cross

⁸ To review information on developing a conceptual framework, see “Pragmatism as a Philosophy of Science: A Tool for Public Administration” by Dr. Patricia Shields.

cultural situations”. This widely used definition is devoid of any specific language that identifies or describes an individual from a minority or underserved population.

Cultural competency awareness has increased in the healthcare industry. However, some health professionals, most notably doctors, seldom acknowledge or take into consideration a patient’s cultural background (Barzansky et al, 2000). Despite the recognized need for more cultural competency training, institutional requirements promoting diversity and cross cultural understanding lag in medical educational settings (Suh, 2004, 94). To address this need, the Association of American Medical Schools created the Tool for Assessing Cultural Competence Training (TACCT). TAACT provides recommendations for curriculum content and identifies educational methods and strategies for evaluating programs (AAMC, 2005). The Association of American Medical Schools seems to be taking a step toward recognizing the need for more culturally competent doctors and putting measures in place to help promote curricula that would benefit doctor and close the disparity gap for patients. TAACT makes recommendations for content and identifies program evaluation strategies, but does not set a standard for the number of hours medical schools should devote to teaching cultural competency, nor address the “informal curriculum” that may influence student learning (AAMC 2005).

There is a gap between the materials and cultural competency resources that are available and an institutions ability to implement those resources. A sizeable collection of data and scholarly writings ⁹ establish the need for cultural competency in healthcare. Unfortunately, materials that outline solutions to the problem or provide action items to help close the gap are not plentiful. Public administrators in healthcare settings contribute to enhancing cultural competency in the health care system by developing a cultural competency handbook for their

⁹ See Tucker et al, 2007, Kleinman & Benson 2006, Sue 2001, Tervalon & Garcia 1998, Lipson & Desantis 2007, Balsa & McGuire 2006, Anderson et al 2003

organization. Depending on whether a health care organization has a cultural competency program or not, the handbook may supplement or act as a substitute.

Cultural Competency Definition

While much of the cultural competency literature discusses the importance of cultural awareness, knowledge, attitudes, and skills, it does not describe how a health system is supposed to become culturally competent. (Brach, 200; Tucker 2006; Suh 2004; Perloff et al 2006). A handbook can enhance competency by providing a clear definition along with information on the critical topics health professionals encounter while working with populations that view the world from different cultural perspectives. For example, an understanding of the complex history between the African American community and the medical profession could be a valuable resource to a nurse counseling a reluctant African American patient regarding treatment options (Brondolo et al, 2008). By exhibiting sensitivity to the historical dynamic this nurse may be better able to ease the patient's fears.

A cultural competency handbook should satisfy the following criteria: define cultural competency, improve health care professionals communication skills (Taylor, 2004, 3), enhance a health care professional's self-awareness of attitudes toward disparate populations, and increase overall knowledge of disparate populations (Brach, 2004, 197). Fulfilling these objectives is critical to the cultural competency handbook because studies show health professionals may display bias towards patients of color (Brach, 2004, 197) and towards patients who are a part of the lesbian, gay, bisexual, and transgender community (Klitzman, 2002, 66). Brach (2004) and Klitzman's (2002) findings demonstrate, health professionals biased against patients who are different from themselves may not provide an appropriate level of care. A cultural competency handbook could soften the perception of these populations to professionals

who may hold some bias and provide these professionals information on how to manage perceived differences. A handbook would also benefit professionals who may unknowingly reduce their effectiveness as providers because they lack knowledge of cultural differences between themselves and patients who come from different backgrounds.

Cultural Sensitivity

Cultural sensitivity means respect for a person's cultural identification and accepting "at the emotional level" when others are expressing their culture (Curry, 2000, 1142). Information regarding sensitivity to the needs of others who are different should be discussed in a handbook. For an increasingly diverse population, health professionals must overcome many barriers to ensure patients are receiving quality care. Cultural sensitivity in healthcare means crafting training programs and messages that meet the cultural needs of a community. Meeting community needs requires awareness of cultural norms, practices, familial roles; among other social norms that vary from one culture to the next (Tucker et al, 2003). Culturally sensitive health professionals are able to identify these nuances. Being culturally sensitive also means a health professional is able to adapt to these diverse populations without injecting personal biases or stereotypes that may prohibit a patient from getting proper care or services (Saha et al, 2003, 1714).

Bergen (2000) points to the ever growing problem of underrepresentation of minority faculty or students in medical schools. The *Journal of the American Medical Association* has thoroughly documented the problem of underrepresentation and accrediting organizations like the Association of American Medical Colleges (AAMC)¹⁰ has provided action based evaluation tools for medical schools. The Tool for Assessing Cultural Competence Training (TACCT)

¹⁰ The AAMC is an association of teaching hospitals, medical schools and academic groups. The AAMC is a non-profit that seeks to improve healthcare by enhancing the effectiveness of academic medicine. AAMC is a member organization of the Accreditation Council for Continuing Medical Education.

measures what elements of a medical school curricula's teaches cultural competency and how those learning objectives are being met (AAMC, 2005). A handbook could provide guidance to health professionals who are serving populations they do not have direct cultural ties with. A handbook should include information to help healthcare professionals be sensitive to and understand the populations they serve.

A cultural sensitivity component should explore receiver based and provider based outcomes between doctors and patients. A discussion highlighting the benefits of cultural sensitivity in health care professionals would be helpful in a handbook. For example, what the patient gets out of the relationship, such as an improved quality of life or overall satisfaction with a healthcare provider (Suh, 2004, 98) is important feedback for a health professional or an organization. Provider-based variables measure what healthcare professionals have learned when following cultural competency models while dealing with diverse populations. For example, a group of nursing students reported improved communication skills along with personal and professional growth in regards to their own value system. Zorn's (1996) study noted the long-term effect of certain cultural competency programs can last for years. This study speaks to the invaluable return on investment an institution can receive by providing employees with tools that encourage being culturally sensitive to others.

Welch (1998) surveyed twenty primary care residency programs that would produce professionals who would go on to serve patients from disparate populations. Of those twenty programs only two had explicit, written goals or objectives related to cross-cultural medicine. Medical residents of all ethnic and racial backgrounds reported providing care to a high percentage of patients from ethnic groups other than their own, but only 41 percent of non-white

and 26 percent of white medical residents reported ever having been exposed to cultural curricula during medical training.

According to Betancourt (2002, 13) cultural sensitivity training should take place in health care settings outside of educational institutions and teaching hospitals as well. Community based organizations should establish and provide culturally sensitive care to individuals within their area. With the gentrification of inner cities or when natural disasters occur, permanently displaced citizens are usually low income or minorities. Therefore community-based organizations establishing cultural competency plans that include cultural sensitivity elements.

When delivering a message (i.e, to improve nutrition, announce new services) to an underserved community, it is important the community considers the source credible. Message strategies must be appropriate and the message must be delivered through mediums frequently used by that community (Kreuter 2004, 442). For example, when delivering services to a low income community investing too heavily in online sources would not reach as many people as say advertisements in public transportation terminals. Focus on the appropriate wording, along with sensitivity to the cultural norms and needs of a population can help health professionals form better relationships with communities. Improving these relationships can increase the quality of care for patients and enhance the interpersonal qualities of the professional.

Interpersonal Qualities

Interpersonal qualities is a key aspect of cultural sensitivity that should be included in a handbook. Healthcare professionals who exhibit qualities such as acceptance, empathy, thoughtfulness, and good listening skills possess culturally sensitive interpersonal qualities that are valued by patients (Tucker 2003, 863). Understanding the patient's needs, good communication and effective relationship building with patients are also qualities health

professionals should adopt in an effort to be culturally competent (Thom et al 2004, 126).

Medical professionals exhibiting these skills encourage positive patient outcomes such as: empowerment, better health management, and health literacy (Stewart 1999, 206).

Interpersonal qualities may help close the disparity gap between patients and medical professionals and should be included in a cultural competency handbook. A handbook should provide basic suggestions such as: demonstrating thoughtfulness, requesting patient feedback regarding the services received to improve quality (Haddad 1999), and spending adequate time with patients. These tips can serve as a reminder, to create a welcoming environment for patients. Since interpersonal relationships are critical to human existence (Hojat 2002, 522) it is imperative the qualities that develop and maintain strong doctor-patient relationships are included in a cultural competency handbook.

Individualized Care

Patients appreciate personalized care and respect. (Tucker, 2003). Individualized care usually incorporates the following values such as: respecting individual respect, fairness and holistic care (Gerrish, 2000, 93). These concepts help patients feel more comfortable with their care team. Suhonen et al (2009, 11) identified nine categories relating to individualized nursing care: nurse's personal characteristics; skill enhancement; ethical issues; care and delivery; patient characteristics; organization of work; staffing; team dynamics and leadership; and management. Simple gestures such as: remembering a name, being sensitive to financial concerns and personal knowledge of a patient's condition are important patient care themes that transcend race (Tucker 2003). This type of care requires health professionals to tailor interactions based on a patient's experiences, behaviors, feelings, and perceptions (Suhonen et al 2009, 2). Individualized care in hospital settings is not the norm (Waters & Easton 1999, 86) , therefore a commitment must exist

within the healthcare institution that cultural competency is an important goal and qualified leaders must ensure all patients are treated as unique individuals (Suhonen et al 2009). Without organizational leadership, individualized care is “unlikely to happen” (Waters & Easton 1999, 86). There are many unsavory stereotypes about modern healthcare professionals, particularly doctors, and many of them elude to a disconnected feeling patients have when interacting with people in the medical field. Including information about individualized care could help healthcare professionals find a more personable approach when interacting with patients.

Socioeconomic Status

Socioeconomic status and health have long been interconnected. (Kaplan, 1998, 229). Health risks generally increase as socioeconomic status (SES) decreases. This pattern remains consistent regardless of the era and geographical locations. A decrease in survival is also consistent with a decline in socioeconomic status. (van Ryn & Burke 2000) The literature debates the causal between SES and health. The relationship between SES and health could reflect selection processes where poor health is the cause of low SES. The competing hypothesis proposes the increased rates of illness among low SES populations is a product of low socioeconomic circumstances. A growing number of cohort studies suggest that, although health-driven downward social mobility occurs, it makes only a minor contribution to SES differences in health (Williams 1995). There is evidence that shows underprivileged people find it more difficult to receive care or access preventive screenings, as compared to those who are considered middle to upper class (Magnus, 2000, 1198). This pattern is true regardless of ethnicity or race (Betancourt et al 2003, 294).

Unfortunately, few articles investigate or measure how well health professionals understand the barriers that exist for low income people seeking health care. Understanding

these socioeconomic needs will help professionals better serve their patients. There is evidence that suggests a patient's SES can impact how a health professional interacts with the patient and can affect diagnosis and treatment (van Ryn & Burke, 2000, 813). The SES component in a cultural competency handbook could provide a guide to help health professionals direct their patients to financial assistance help (Tucker, 2003). For example, if a patient demonstrates the need for financial assistance for co-payments or difficulty obtaining medical supplies, a handbook can provide guidance to the healthcare professional for addressing those needs.

Mistrust

A person's past experiences will often influence an individual's ability to trust. But what happens when an entire population of people has a clear memory of incidents that involved cover ups, harmful experimentation, and the medical establishment? Analysis of relationships between minority patients and healthcare professionals show there are lingering feelings of mistrust traced to diminished faith in healthcare professionals and lower participation in clinical trials (King, 2003).

Much of the literature pertaining to a distrust of the medical industry by people of color point to the Tuskegee Study of Untreated Syphilis in the Negro Male as the most likely cause of the distrust. In a study that explored the level of knowledge and awareness regarding this event, 76.6 percent of African American respondents believe a study such as the Tuskegee experiment could occur today. That's compared to only 47.2 percent of Anglos (Brandon, 2005, 953). King concluded a greater number of more ethnically diverse staff members could help ease some of the decades old tensions present between healthcare professionals and patients from disparate populations.

Mistrust may be patient based or originate from the health professional. Patients with lower levels of collectivism are more likely to mistrust health institutions. Collectivism refers to how individuals value cooperation, interdependence, and relationships with others (Halbert et al 2009, 2558). These patients are more likely to have communication styles that are “unsupported during clinical encounters” (Halbert et al 2009, 2559). Poor communication with a provider can also lead to mistrust if patients cannot properly communicate their concerns. Communication skills training for disparate populations could help patients provide more information to their doctors who, in turn provide more accurate treatment options or health plans and improve patient satisfaction.

Sexual Orientation

The 1999 *Institute of Medicine Report* and Healthy People 2010 note that, as a group, people who identified as homosexual were less healthy as compared to heterosexuals. Research indicates that women who have sex with women are less likely to utilize preventive clinical care such as mammograms and Pap tests (Kerker, 2006). Medical resources primary care providers commonly use in making treatment decisions pay little or no attention to issues of care for lesbian, gay, bisexual, and transgender (LGBT) individuals. A prevalent example is the widely used medical textbook by William T. Branch's primary called *The Office Practice of Medicine*, published in 2003. This textbook presents the proper approaches to conducting successful interactions with adults patients. Yet it does not mention the words "gay" and "lesbian" in neither the table of contents or index. Where textbooks and other major bodies of work healthcare professionals rely on fail to report on the LGBT population, a cultural competency handbook could be the tool that provides non-biased health information to ensuring lesbian, gay, bisexual, and transgendered patient related needs are properly addressed.

Members of the LGBT community may avoid routine medical visits as a result of a past negative experience caused by a healthcare professional not being culturally competent (Healthcare Equality Index, 2008, 9). The Gay and Lesbian Medical Association has made cultural competency one of its most important goals (GLMA, 2006). This organization has partnered with the world's largest LGBT advocacy organization, the Human Rights Campaign, in a study that examine hospital cultural competency levels. Of the eighty-eight hospitals and treatment facilities that responded 69 percent reported having diversity or cultural competence training that "addresses issues related to LGBT patients and their families"¹¹. Most of the reviewed cultural competency literature¹² offered very little information about this community. One of the reasons may be the level lack of data available about the LGBT community (Harcourt, 2006, 2). Another reason may be the level of diversity within this community. LGBT people are represented in every racial group, and are comprised of both women and men within all socioeconomic groups (Harcourt, 2006, 2).

Communication

A section on communication should also be included in a cultural competency handbook. The literature¹³ recognizes the important role of culture as a factor that can help bring about better outcomes and increased communication. This focus on culture coincides with national health objectives that seek to eliminate disparities between different population subgroups on a wide range of health-related outcomes and behaviors.

While cultural barriers hinder communication, language barriers also cause communication problems. One study noted,

¹¹ See Healthcare Equality Index (2008, 9) for further discussion on LGBT inclusion in the hospitals that participated in the study.

¹² See Ridley et al 2001; Suhonen et al 2007; Capell et al 2008; Betancourt et al 2006; Tucker et al 2003

¹³ See Kreuter (2004, 439); Flores 2006; Guerra et al 2008

“Language and cultural barriers to health communication among non-English speaking patients may partly explain racial and ethnic disparities in processes and outcomes of health care. However, surprisingly little is known about how language and cultural barriers affect communication” (Fernandez et al 2004, 167).

Poor communication between health care professionals and patients of color has been observed in the healthcare setting, however, the root causes have received very little attention (Ashton 2003). Healthcare professionals must be able to express to patients and clients, with patients’ their words and actions, they are committed to and have the proper skills needed to address a medical concerns. Since the problem, poor communication between health care professionals and patients has been identified, a handbook should provide workable solutions that help health care professionals communicate with patients in an effective and professional manner. In planning health related communication campaigns, health care professionals must locate credible sources, choose a message, and find the proper setting in which to communicate that message (Kreuter & McClure 2004). This is also known as the communication/persuasion model (McGuire 1989), a widely researched topic that indicates message content and structure can be perceived in a variety of ways across various demographics.

There is evidence to suggest that is malpractice claims decrease, patient satisfaction increases, and patients adhere to recommended treatment options when patients and healthcare professionals are communicating with one another (Suh 2004, 98). As a result of these findings, a cultural competency handbook should include a communication component that places emphasis on overcoming language barriers and increasing health literacy.

Language Barriers

In a study of Spanish speaking diabetics, patients reported better interactions with health professionals that spoke Spanish and were less satisfied with their care if the healthcare worker

was not a Spanish speaker (Fernandez et al, 2004, 172). However, because patients may immigrate to the U.S. speaking many different languages and a variation of dialects, it is impossible for one health facility to have staff who can speak the myriad of patient languages. One solution to this is would be to hire qualified multicultural staff. Unfortunately, fiscal and staffing shortages exist. A more feasible and less expensive solution would to utilize interpreter services.

According to Elizabeth Jacobs et al (2004, 866), most health care organizations provide either inadequate interpreter services or no services at all and as a result, patients who have limited English language skills may not receive needed or quality healthcare. Often, individuals enlisted to help patients communicate with providers are not trained interpreters; instead, they may be fellow patients or a family member, friend, or some other untrained nonclinical employees. Considering the type of personal information being exchanged during a doctor visit, this can lead to unsettling consequences not only for the patient, but for the person translating, especially if that individual is a family member or friend.

Jacobs (2004, 866) goes on to note,

“Many health care providers do not provide adequate interpreter services because of the financial burden such services impose. However, these providers fail to take into account both the consequences of not providing the services and the potential cost benefits of improving communication with their patients. The failure of health care providers to consider these issues is at least partially attributable to the paucity of data documenting the full costs and benefits of interpreter services. To acquire a better understanding of these costs and benefits, we assessed the impact of implementing a new interpreter service program on the cost and utilization of health care services among patients with limited English proficiency”.

However, for those hospitals that do have translators, a recent article in the *Journal for General Internal Medicine* may shed light on how often doctors use the services available to them. This study observed teaching hospitals in the State of California. Translation services for health care providers in California is very important since forty-three percent of Californians do

not speak English at home. Many hospitals in the state have well developed translation services, but there are health care professionals who admit they do not use translators on their staff for various reasons. Some doctors acknowledged they were not using interpreters when they should, many felt the time it would take to contact an interpreter and have that person walk to the patient area would interfere with the amount of time it took them to make their rounds. The physicians that participated in the study felt this kind of behavior was acceptable and the behavior did not diminish the quality of care given to non-English speaking patients (Diamond et al, 2009, 256).

For this research, resident physicians were asked to describe their own and their colleagues' underuse of interpreters. Many of the doctors coined the term "getting by," to describe the lack of use. "Getting by" meant communicating through gestures, using limited second language skills, and relying on medical records provided by past doctors. All of the resident physicians recalled instances of their own non-use of interpreters. One resident physician explained the practice as:

"[A] lot of times you can position them the way you want them to and then just listen to their lungs or their hearts without them having to really do much of anything... [Y]ou can mimic things; if you are asking them if they have vomited overnight, you can imitate throwing up and they will be like, 'Oh no, no, no' or 'yes, I did.' It's difficult to get details surrounding that but you can get a general idea."

Patients who have limited English proficiency need to be able to communicate with their healthcare professionals in an efficient manner. Some organizations, such as the American Cancer Society, provide language services through the AT&T Language Line. This is a commercial service that is available by phone and provides twenty- four hour interpretation in more than 120 languages (Hornberger, 1997, 411).

Professional interpreters can help remove language barriers between health professionals and patients. Some 18.7 percent of Americans speak a language other than English at home and

8.4 percent have very limited English proficiency (Flores, 2006, 229). The use of interpreters in healthcare is a concept that emerged from states that saw a large increase in primarily Hispanic and Asian immigrant patients. The literature reflects more research still needs to be conducted done on this topic, but the available studies¹⁴ overwhelmingly indicate language barriers between healthcare professionals and patients negatively impact healthcare. Unfortunately, obstacles can stall or slow an institutions ability to supply interpreter services to patients. Some care facilities do not have the funding to provide this service and as one study noted, physicians were less likely to use interpreters because of perceived time constraints and did not deem interpreters a necessity when conducting routine checks (Diamond, 2009, 256).

The lack of trained medical translators or underuse of these professionals can have unintended negative consequences. Patients who do not speak English well or at all, may experience higher misdiagnosis rates, longer hospital stays, reduction in access to preventive care services, and may not be able to understand medication instructions. Diamond et al (2009) found doctors at facilities that provide trained professional translators, may underuse those translation services. Administrators should explicitly express the importance of these services to clinical staffs, so all patients and clients can be served much more effectively. Better use of interpreter services could also benefit an organization's fiscal health, since it could mean shorter hospital stays for patients and a decrease in the number of people who are misdiagnosed. A handbook should stress the use of translation services and the potential for positive patient outcomes.

¹⁴ See Diamond et al 2009, Flores 2006, Hornberger et al 1997, Jacobs et al 2004, McCabe 2006, Zambrana et al 2004

Health Literacy

Quality patient-provider based communication means patients understand health information and treatment guidelines. Patients should feel comfortable enough to ask questions or to admit when they may not understand instructions. This comfort level is vital to successful individual health management. However, this ideal level of communication is difficult because of individual and cultural differences. These differences may include the way patients understand health concepts or how they view the power dynamic between themselves and the healthcare provider (Barrett, 2008).

A healthcare professional must communicate (verbally and non-verbally) in a manner sensitive to a patients' ability to understand and interpret English. The ability to read proficiently in English is vitally important when providing care to a patient who is receiving prescribed medication. Understanding the issues of health literacy; culture; and communication and its implications are critical to improving patient and clinician communication, quality care, and self-management for health conditions (Barrett, 2008).

Health literacy is something many health professionals may take for granted or simply overlook, but is equally important to immigrant patients who have low English skills, and English speaking patients. More than ninety million adults in the United States have poor literacy skills. This means these adults would have trouble finding pieces of information or numbers in a lengthy text, difficulty integrating multiple pieces of information in a document, finding two or more numbers in a chart, and performing a calculation. Those with poor reading skills have greater difficulty navigating the health care system and are at risk of experiencing poorer health outcomes (Berkman, 2004). Illiteracy may also hinder a person's ability to function in a health care environment, which increasingly relies on complex written information.

Historically, the average reading level of patient materials related to health care was eleventh to fourteenth grade, but the average person's reading level is much lower. Additionally, even patients who read at the college level prefer medical information written at the seventh grade level (Berkman, 2004, 22).

The ability to understand and act on health information is called health literacy (Barrett, 2006, 691). Health literacy involves being able to communicating with healthcare professionals to understand a condition and making informed decisions that prevent, manage, or resolve a health problem. Low health literacy is an underreported problem in our nation and nearly half of all American adults in 2004 had difficulty understanding and acting on medical information (Barret, 2006, 691). Many patients encounter problems reading and understanding discharge instructions, medication labels, patient education materials, consent forms, or health surveys. Properly assessing the literacy level of patients helps health professionals create appropriate materials for patients with low literacy levels (Pignone et al 2004).

Two organizations that address health literacy do so from different perspectives. The American Cancer Society provides cancer specific information to the public. For each cancer document there are two versions available; an overview written at a lower reading level and a comprehensive document which is more detailed and written at a higher reading level. Constituents may also request a cancer glossary to accompany any cancer related materials sent to them at no charge. The American Medical Association has created an awareness campaign to educate healthcare professionals and patients to understand the dangers of poor health literacy. The programs assess the level of education for populations served and provide materials at the appropriate reading grade level. Illiteracy can be a sensitive subject and a handbook should

provide guidance for how a health professional can turn that difficult conversation into one that leaves the patient feeling informed, with dignity intact.

Handbook Layout

An effective cultural competency handbook tailors its message to meet the needs of the health professional within the organization for which it is written. The handbook should be informative, easy to navigate, and make use of simple terms without being overly informal (Devon, 2007, 42). To fulfill these requirements, initial preparations must occur. The preparations include: investigating, compiling and writing; reviewing and revising; and legal approval (Guerin and DelPo, 2007, 9). This is known as the drafting process. In order for the cultural competency handbook process to be successful, the entire organization must commit to the concept; from the highest executive on down.

The authors should also review cultural competency literature from similar facilities in their area and gather feedback from employees through questionnaires and interviews (Guerin and DelPo, 2007, 10). Once the information from the investigation is compiled, the writing process begins. A cultural competency handbook should use simple vocabulary, and short sentences and paragraphs. The use of jargon should be avoided and language that reflects the culture of the organization should be used to remain consistent with other employee reading materials. Authors of a cultural competency handbook should write to the education and sophistication level of hospital employees and use terms consistently. Writers should explain the rationale behind the policy when appropriate to give the reader a better perspective on the topic (Guerin and DelPo, 2007, 10).

After the initial draft of the handbook is complete, supervisors should review and revise, providing additional feedback. These reviewers can alert the authors to inconsistencies (Guerin

and DelPo, 2007, 11) and to cultural competency solutions that may not be applicable in the “real world”. During the review and revision stage, new or different information may be introduced. After the authors prepare the final draft of the cultural competency handbook, it must be sent for final approval from an attorney within the organization for review (Geurin and DelPo, 2007, 11) to ensure the document is legally sound.

Organizing a Cultural Competency Handbook

A positive and upbeat “welcoming” statement sets the tone for a cultural competency handbook (Geurin and DelPo, 2007, 16). Cultural competency may be an uncomfortable topic for some health professional because it means asking someone to evaluate or to modify their behavior. A warm opening statement that addresses that apprehension in a respectful manner could help “break the ice”. After this statement, readers should find the table of contents. The tables of contents introduces the reader to the topics within the handbook and is usually the most used section within the handbook. Readers use the table of contents to find answers to their specific questions (Geurin and DelPo, 2007, 12). Employees should read the cultural competency handbook (Devon, 2007, 48) so the section titles in the table of contents should be simple and straightforward. The introduction follows the table of contents. This section should include general company information (Devon, 2007, 40) along with the mission statement of the organization. A company mission statement is a succinct way to give employees an understanding of the purpose of a company. Often, a mission statement directly or indirectly address full inclusion by identifying federal and state non-discrimination policies. Addressing patients’ needs speaks to the heart of cultural competency.

Cultural competency handbook introductions may include a myriad of information. Introductions may include a heart-felt description of an organization's values or the types of

services it provides (Guerin and DelPo, 2007, 19) to patients. However, there are some key elements that should be taken into consideration while drafting this section. Authors should consider highlighting values that are most important to an organization and explain why the organization holds those values in high esteem. The introduction should also focus on the professional organizational standards expected of employees are expected to display in the workplace (Guerin and DelPo, 2007, 19). Providing this information at the beginning of a cultural competency handbook is in step with the upbeat “welcome” message and builds upon the positive qualities of the staff and organization.

A “statement of purpose” should follow the introduction. This section explains why the cultural competency handbook is important and how it should be incorporated within the workplace (Guerin and DelPo, 2007, 22). How an employer introduces the cultural competency handbook may determine how well the health professional receives the handbook.

As the cultural competency handbook progresses, it should highlight issues some may find uncomfortable; such as poverty, homosexuality, and racial discrimination. These difficult categories should feature a friendly tone from the beginning of the handbook. At the end of a cultural competency handbook, the authors may consider adding an index to help employees quickly find what they are looking for (Guerin and DelPo, 2007, 12). They may also consider state and federal resources that provide additional cultural competency information for other learning opportunities.

Chapter Summary

Analysis of the cultural competency components has shown the need to develop a preliminary model for a handbook. A cultural competency handbook preliminary model would contain components that act as building blocks to improve the quality of communication, care and increase levels of understanding between disparate populations and their health care providers. The elements of this preliminary model represent the most important aspects of cultural competency with regard to health care. Chapter four discusses the methodology used to conduct this study.

Table 3.1 summarizes the conceptual framework and connects components in the practical ideal type to the literature (shields 1998; Shields & Tajalli 2006).

**Table 3.1: Cultural Competency Handbook Preliminary Model:
Components Tied to Literature**

Ideal Categories	Sources
Cultural Competency	Capell et al (2007); Suh (2004); Betancourt (2004); Welch (2008); Balsa & McGuire (2003); Ridley et al (2001); Sue (2001); McCabe (2006); Anderson et al. (2003); Barzansky (2000)
Definition	Suh (2004); Kreuter & McClure (2004); Perloff (2006); Tervalon & Murray-Garcia (1998); Kreuter et al (2005); Capell (2008); Rorie (1996); Cross (1989)
Cultural Sensitivity	Bergen (2000); Curry (2000); AAMC (2005); Saha (2003); Tucker et al. (2003); Surbone (2008); Kreuter et al (2005)
Interpersonal Qualities	Thom et al (2004); Tucker et al.(2003); Stewart et al (1999); Haddad et al (2000); Hojat (2002); Campbell (2007); Capell et al (2008)
Individualized Care	Gerrish (2000); Tucker et al. (2003); Rorie (1996); Waters and Easton (1999); Suhonen et al (2009); Suhonen et al. (2007);
Socioeconomic	Tucker et al. (2003); Mangus (2000); Betancourt, et al (2003); van Ryn & Burke (2000); Willems (2005);
Mistrust	Brandon (2005); King (2003); Guerra et al. (2008); Brondolo et al (2009); Benkert et al (2006); Halbert (2009);
Sexual Orientation	Klitzman & Greenberg (2002); HEI (2008); GLMA (2006); Harcourt (2006); Eliason & Schope (2001)
Communication	Kreuter and McClure(2004); Suh (2004); Ashton (2003); McGuire (1989); Street et al. (2007); Houts et al. (2006); Tucker et al. (2003); Halbert et al (2009)
Language Barriers	Diamond, et al (2009); Flores (2006); Johnston et al. (2006); McCabe (2006); Gregg & Saha (2007); Jacobs et al. (2004); Andrulis & Brach (2007); Anderson et al (2003)
Health Literacy	Barrett (2008); Halbert et al. (2009); Neuhauser & Kreps (2008); Balsa & McGuire (2003); Berkman (2004)
Handbook Design	Devon (2007); Guerin and DelPo (2007)

Chapter 4: Methodology

Chapter Purpose

This chapter describes the methods used to improve the cultural competency handbook framework developed in the previous chapter. Chapter 4 also discusses the limitations of this research and protection for human subjects.

The primary method of analysis is focused interviews of Health professionals who provided their expert opinions to this applied research project.

Table 4.1: Operationalization of Focused Interview Query

<u>Preliminary Model Component</u>	<u>Query</u>	<u>Possible Response(s)</u>
Preliminary Model	Please review the categories in the preliminary model. Are all of the categories listed in the preliminary model relevant to a Cultural Competency Handbook?	Yes/No
	Please consider the categories in the preliminary model. Should any categories be added or eliminated? If so, what would you eliminate or add?	Varies from Model
Cultural Competency	Please review the elements in the “Cultural Competency” category. Should any be eliminated? If so, which one?	Varies from model
	Please review the elements in the “Cultural Competency” category. Should any be added? Is so, what?	Varies
Cultural Sensitivity	Please review the elements in the “Cultural Sensitivity” category. Should any be eliminated? If so, which one?	Varies from model
	Please review the elements in the “Cultural Sensitivity” category. Should any be added? Is so, what?	Varies
Mistrust	Please review the elements in the “Mistrust” category. Should any be added? Is so, what?	Varies

Sexual Orientation	Please review the elements in the “Sexual Orientation” category. Should any be added? If so, what?	Varies
Communication	Please review the elements in the “Communication” category. Should any be eliminated? If so, which one?	Varies from model
	Please review the elements in the “Communication” category. Should any be added? If so, what?	Varies
Handbook Design	Please review the elements in the “Handbook Design” category. Should any be eliminated? If so, which one?	Varies from model
	Please review the elements in the “Handbook Design” category. Should any be added? If so, what?	Varies

Focused Interviews

Health professionals were interviewed for this project by phone for this project. In *The Practice of Social Research* Babbie (2004, 249) notes, telephone interviews are cost effective and convenient which made this method well suited for this applied research project. The interviews were used to evaluate the preliminary model and discover ways to improve upon it. During the interview, experts were asked to evaluate the components and elements to the overall system for relevancy. The average time for the interviews was twenty-five minutes, with twenty being the shortest and thirty-seven minutes being the longest. The interviews took place from July-September 2009.

Unit of Analysis

The units of analysis for the research are healthcare professionals in the United States. These medical staffers, hospital administrators and managers were interviewed because he or she acts in a role that delivers health care to underserved patients.

Interview Population

The ten experts interviewed were selected from a number of organizations and care facilities from Washington D.C., Texas, and California. All of the experts deal directly with patients and have medical, nursing or health care administration degrees. The experts were contacted via through professional and personal networks. The candidates selected represent a broad cross section of health care professionals. All of the feedback was provided by individuals who are in the field and dealt directly with patient services. The final list of experts chosen consist of: three nurses, two medical doctors, one medical student, one hospital administrator, one manager at a public health non-profit, and two nursing students. Each interviewee interacts with a diverse set of patients on a frequent basis. The health care professionals who participated in this study were chosen using the purposive (judgmental) sampling method¹⁵.

Questions to be Presented

The questions presented during the interview follow the preliminary model. A combination of open ended and closed questions were used to during the interviews. The open ended inquiries allowed experts to contribute valuable information that would benefit in forming a new model. Closed ended questions showed whether or not an expert believed a particular component belonged in the model or not.

Interviewees were shown a copy of the preliminary model then asked to provide feedback on the model as a whole. Components were then separated and experts were asked to evaluate each on its own based on it being valid and sufficient. For example the “Cultural Sensitivity” category has three elements: Interpersonal qualities, Individualized care, and Socioeconomic status. Interviewees were asked to review the elements and provide feedback on any additions or removals.

¹⁵ See Babbie 2007, 183

Limitations of Research

This applied research project identifies a goal health care organizations should work toward when creating a cultural competency handbook. Since care facilities target different populations depending on their location it is important to note, the categories listed in this paper may only represent fundamental set of ideals to be included. Each organization should determine if any additional categories are needed in their final cultural competency handbook. Hence each handbook will be slightly different based on that organization's needs.

Human Subjects Protection

Prior to conducting any interviews this research project was cleared in writing by the Institutional Review Board of Texas State University-San Marcos and found to be exempt from review. The Texas State University Internal Review Board exemption ID is EXP2009H8805. No confidential information was collected during the research process, therefore disclosure of privacy practices was not warranted. The research purpose was stated at the beginning of the interview process. Information related to the research was shared with interviewees in advance. The results of opinions and feedback by interviewees were not linked to particular individuals. No exchange of monetary or compensatory benefits were provided for participating in this research. An email of appreciation was extended after concluding each interview. No confidential data was released throughout the research process. The research advisor was:

Patricia M. Shields, PhD
Director of Masters in Public Administration Program
Texas State University in San Marcos
601 University Drive
San Marcos, Texas 78666

Chapter Summary

This chapter provided information about the interview inquiry and basic information about the individuals interviewed for this project. The chapter also discusses the steps that were

taken to ensure the proper protections for human subjects were followed. In the following chapter, the results of the study are disclosed.

Chapter 5: Results

The purpose of this chapter is to discuss the data received for this applied research project. Detailed results of the focused interviews are discussed and correlated to the preliminary model components.

Preliminary Model Results

All of the preliminary model components were discussed during the interview process. Interviewees were asked to evaluate each component and determine if items should be added or removed. The respondents were also asked to provide feedback after reviewed the entire model. Feedback was provided on the relevancy of the topics to be included in a cultural competency handbook and how the handbook should be organized. This section of the results chapter presents the components and discusses the respondents feedback.

Cultural Competency

For the “Cultural Competency” portion of the interview experts were asked to consider the components and their order in relation to a cultural competency handbook:

- Definition
- Techniques

Most of the interviewees agreed the “Cultural Competency” component was essential to a handbook. However, out of the ten responses, one respondent from the pool of experts recommended this section be changed. This recommendation came from a nurse who suggested the “Definitions” section be omitted and included in an overview section towards the beginning of the handbook. The response rate for this section was 100%.

Cultural Sensitivity

For the “Cultural Sensitivity” portion of the interview respondents were asked to consider the components and their order in relation to a cultural competency handbook:

- Interpersonal Qualities

- Individualized Care
- Socioeconomic Status

The following changes were recommended for the “Cultural Sensitivity” component from the experts interviewed for this project. The medical student recommended adding a cultural customs component to the model. This addition would require extensive research that would need to cover many different cultures and identify the customs that have a direct effect on the health of that particular population. It was suggested the “Socioeconomic Status” component be eliminated from the model. The respondent who suggested this change is a nurse and felt a patient’s socioeconomic status had no direct impact on care. The response rate for this section was 100%.

Mistrust

During the “Mistrust” portion of the interview respondents were asked to consider the components and their order in relation to a cultural competency handbook.

The healthcare administrator felt a cultural competency handbook should have in the “Mistrust” section a copy of that organization’s privacy policy. This respondent felt a considerable amount of mistrust patient’s feel stems from the fear of information leakage. One medical doctor felt the “Mistrust” component should have information identifying prominent ethical missteps in medicine to reinforce why patient’s in certain cultural groups have low levels of trust for health professionals. This could include an overview of the Tuskegee Syphilis Studies and other historical examples of medical professionals showing bias against individuals who were ethically or culturally different from most White Americans. The response rate for this section was 100%.

Sexual Orientation

For the “Sexual Orientation” portion of the interview respondents were asked to consider the components and their order in relation to a cultural competency handbook.

The following changes were recommended for the “Sexual Orientation” component from the experts who participated in the focused interview process. The first recommendation for this section called for a completely separate handbook that discussed cultural competency as it relates to sexual

orientation. This suggestion was provided by one of the nurses interviewed for this applied research project. The second recommendation came from a medical student who suggested a handbook should provide information on “Creating a Safe Space for LGBT Patients”. Confidentiality is very important to many in this community for a myriad of reasons. One way health professionals can put LGBT patients at ease is by ensuring their confidentiality as a patient and as a member of an alternative community. The respondent also believed a section that highlights “Screening and Education for LGBT Wellness” should be included in a cultural competency handbook. Information regarding common health issues within the LGBT population would be useful to health professionals. This section could be used to help doctors and nurses with screening recommendations and targeted sexual health information. The response rate for this section was 100%.

Communication

In the “Communication” portion of the interview respondents were asked to consider the components and their order in relation to a cultural competency handbook.

- Language Barrier
- Health Literacy

The following changes were recommended for the “Communication” component from the experts who participated in the focused interview process. First, respondents felt guidelines for translating documents from English to other languages should be provided to patients. This would include a glossary of medical terms. Next, three respondents (all are nursing students) recommended phrasings should be included in a handbook along with audio communication tools for patients who do not speak English. The audio communication tools would be websites or videos that cover various health topics in a variety of different languages. According to the respondents it is important healthcare professionals are able to communicate with patients using culturally appropriate language. As an example, one of the nurses describes the different dialects within the Latino community. A word in Columbia may have a different meaning in El Salvador. This nurse felt a cultural competency book should acknowledge this important point. The response rate for this section was 100%.

Handbook Layout

In the “Handbook Layout” portion of the interview respondents were asked to consider the components and their order in relation to a cultural competency handbook. The following changes were recommended for the “Handbook Layout” component from the experts who participated in the focused interview process. All of the respondents agreed any images used within a cultural competency handbook properly represent a variety of ethnicities and cultures. The public health non-profit manager stated “a cultural competency handbook should have people of all shades on the cover and throughout the guide.” This respondent also felt the pictures used in a handbook should have a fair amount of smiling faces and images of people expressing a level of care and consideration for one another. The hospital administrator interviewed believed careful consideration should be given to the print type and font colors. It is important to note all respondents felt the handbook layout should be guided by the institution that will produce the handbook but should include the categories in this applied research project. However, the order of the categories along with the color scheme and font type should be based on the input of the individuals organizing the handbook. The response rate for this section was 100%.

Chapter Summary

The experts interviewed for this applied research project were very pleased with the model. There were some minor changes to some of the categories, but the most important changes were the elimination of the socioeconomic component and the sexual orientation component be a completely separate handbook. The latter suggestion speaks to an urge on the part of professionals to learn more about the lesbian, gay, bisexual and transgender community and their specific health needs. The final chapter summarizes the information discussed in the results chapter and reveals the revised model for a cultural competency handbook.

Chapter 6: Conclusion

Chapter Purpose

The “Conclusion” chapter summarizes all of the information introduced in the “Results” chapter and presents the revised preliminary model developed during the research. This chapter also provides future professional inquiry possibilities for cultural competency handbooks.

Revised Cultural Competency Handbook Model

This section summarizes the deletions, additions and other changes made to the preliminary model. Table 6.1 shows the revised model.

Addition of New Categories

The feedback from the research did not identify any categories that should be added to the model.

Deletion of Existing Categories

One respondent suggested the “Sexual Orientation” category be deleted and become a completely separate handbook. However, most respondents felt this section deserved to be included in a cultural competency handbook. Future research may yield a sexual orientation focused cultural competency handbook to compliment a general cultural competency handbook.

Other Recommended Changes

The information examined in the “Results” chapter was integrated with the components from the preliminary model to create an overhauled model. The “Cultural Competency” category is the only component that did not add new elements. The revisions are as follow:

Cultural Competency

One respondent felt the “Definition” component should only appear in the overview section of a cultural competency handbook. This is a great consideration, however, since there are a number of different definitions for cultural competency it is important those varying interpretations are identified and discussed. This discussion could lead to a better understanding of what cultural competency is.

Cultural Sensitivity

A key consideration for this section is the addition of a “Cultural Customs” (See Table 6.1) component. Each agency or institution can identify the populations they serve and provide targeted information regarding common cultural practices and health. The “Socioeconomic” component is in the handbook since it has been identified in the literature as a barrier to competent healthcare for low income patients.

Mistrust

For this section a component that acknowledges historical ethical misstep titled “Historical Perspective” should be included. This component would identify high profile cases of unethical behavior in medicine and extreme consequences of such actions in today’s society. Also, a component that discusses “Health Information and Privacy” (See Table 6.1), which ushered in a new era of patient confidentiality and protections with the Health Insurance Portability and Accountability Act of 1996 also known as HIPAA ¹⁶ should be included.

Sexual Orientation

There was one recommendation for this component, however it did not meet the standard to be included in the handbook.

Communication

Some of the respondents strongly felt “Recommended Phrasing” should be added as a component to assist health care professionals. This would provide alternative terms or phrases health professionals can use that the average person will understand. Another consideration is to provide a component that discusses “Translation Guidelines”. A handbook should provide appropriate guidelines for translating information from English to other languages. Translations should be culturally appropriate, the wording should be accurate, and at the appropriate reading level. The final consideration is to provide a list of

¹⁶ HIPAA provides federal protections for personal health information and gives patients an array of rights with respect to that information. HIPAA is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

communication tools available to healthcare professionals. This may include the phone number to in-house translators or a language line.

Handbook Layout

Key considerations for this category include the addition of the following components to this category “Culturally Representative Photos” and “Font Type” (See Table 6.1). Respondents felt a handbook should place some emphasis on the types of images and photographs chosen for a cultural competency handbook. The images should represent people of all colors and from a variety of cultures. A handbook should address the importance of choosing the proper font so that the text is simple to read and has character. Table 6.1 introduces a revised Cultural Competency Handbook Model with Corresponding Elements.

Table 6.1: Revised Cultural Competency Handbook Model with Corresponding Elements

Categories	Corresponding Elements
Cultural Competency	<ul style="list-style-type: none"> • Definition • Techniques
Cultural Sensitivity	<ul style="list-style-type: none"> • Interpersonal Qualities • Individualized Care • Socioeconomic Status • <i>Customs Cultural</i>
Mistrust	<ul style="list-style-type: none"> • <i>Historical Perspective</i> • <i>Health Information and Privacy</i>
Sexual Orientation	<ul style="list-style-type: none"> • <i>Creating a Safe Space for LGBT Patients</i> • <i>Screening and Education for LGBT Wellness</i>
Communication	<ul style="list-style-type: none"> • Language Barriers • Health Literacy • <i>Translation Guidelines</i> • <i>Recommended Phrasing</i>
Handbook Design	<ul style="list-style-type: none"> • <i>Culturally Representative Photos</i> • <i>Font Type</i>

Suggestions for Future Studies

Creating an ideal Cultural Competency handbook can be a continuous work in progress. A variety of revisions and expansions can be made to this model. In the case of this project, an outcome analysis that measures the validity and the effectiveness a cultural competency handbook has on reducing disparities would be helpful. There is also an opportunity to examine the relevancy of each category in this practical ideal type to various ethnic populations. With that information this model can be revised to meet the needs of targeted groups using an abbreviated or expanded version of the original model.

Chapter Summary

This chapter summarized the recommendations from the previous chapter, which included adding new components to the overall ideal type. In addition to the revisions, an overview of the studies limitations and future suggestions for research were also presented.

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