

Creating Culturally Competent Health Care Organizations: Six HUMANE Steps

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by Phillip E. Jackson

Census reports in the United States indicate that America’s population is growing increasingly diverse. In 1900, only one in eight Americans was of a race other than white. Today, that ratio is one in four. It is estimated that by 2050, the Hispanic and Asian populations will both triple; the black population will almost double; and the white population will barely hold its own (Salisbury & Byrd, 2006, p. 90). As the United States become more ethnically and racially diverse, there is a need for health care organizations that will reflect and respond to an increasingly heterogeneous community (Salisbury & Byrd, 2006).

This new challenge has implications for every aspect of health care: the workforce, leadership and most importantly, the communities served. Knowing how to serve people with different values, health beliefs and alternative perspectives about health and wellness, is both a business and ethical imperative.

This article explores why cultural competence matters in health care, recommending six HUMANE steps for developing culturally competent health care organizations. These steps are: 1) Hiring a diverse workforce, 2) Understanding the communities served, 3) Making cultural competence a top priority, 4) Adopting culturally and linguistically appropriate health care practices, 5) Nurturing a service-learning model, and 6) Evaluating progress and continued development. The use of the acronym “HUMANE” also symbolizes the call for a more compassionate health care system. It reflects what is most important in health care: the patients and their unique cultures, values and beliefs.

What is Cultural Competence?

Cultural competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by the communities served.

The U.S. Department of Human & Health Services (2001) defines cultural competence as a set of cultural behaviors and attitudes integrated into the practice methods of a system, agency or its professionals that enables them to work effectively in cross-cultural situations. Cultural competency is thus achieved by translating and integrating knowledge about individuals and groups of people into specific practices and policies applied in appropriate cultural settings.

Similarly, Anderson et al. (2003) say that cultural competence refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.

Why Cultural Competence Matters in Health Care?

Why does cultural competence matter? First, this article does not attempt to address the mountain of research published over the past several years. Instead, it focuses on a few landmark reports that capture the spirit of why cultural competence matters. Consider the following reports:

1. In 2002, the Institute of Medicine (IOM) published a groundbreaking report, titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, which illuminated one of the most critical health care challenges facing the United States. The IOM's findings that racial and ethnic minorities received lower-quality health care than white people, even when insurance status, income, age and severity of conditions are comparable, for the first time gave evidence-based credence to the assertion that the U.S. health care system is not color blind. The report offered comprehensive evidence to an uncomfortable reality that some people in the United States were more likely to die from cancer, heart disease and diabetes simply because of their race or ethnicity, not just because they lack access to health care (p. 3).
2. In a 2001 national survey conducted by The Commonwealth Fund, a private foundation that aims to promote a high performing health care system, 39% of Latinos, 27% of Asian Americans, 23% of African Americans and 16% of whites reported communication problems with their doctors, including the doctor not listening to everything they said, not fully understanding what the doctor said or not asking the questions they would have liked to ask during their visit (Collins et al., 2002, p. vii).

3. A 2006 National Healthcare Disparities Report by the Agency for Healthcare Research found that disparities related to race, ethnicity and socio-economic status pervaded the American health care system. The report notes that disparities were observed in almost all aspects of health care, although varying in magnitude by condition and population. Below is a summary of the findings of this report (p. 2):

- Across all dimensions of quality of health care including: effectiveness, patient safety, timeliness and patient centeredness.
- Across all dimensions of access to care including: facilitators and barriers to care and health care utilization.
- Across many levels and types of care including: preventive care, treatment of acute conditions and management of chronic disease.
- Across many clinical conditions including: cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health and substance abuse and respiratory diseases.
- Across many care settings including: primary care, home health care, hospice care, emergency departments, hospitals and nursing homes.
- Within many subpopulations including: women, children, elderly, residents of rural areas and individuals with disabilities and other special health care needs.

Six HUMANE Steps for Developing Cultural Competence

The National Conference of Catholic Bishops (1981) argues that health and health care are subjects that profoundly touch the lives of us all. The Conference of Bishops explains one's ability to live a fully human life and to reflect the unique dignity that belongs to each person is greatly affected by health. Furthermore, because all human beings are created according to God's image, they possess a basic human dignity, which calls for the utmost reverence. The Bishops conclude that health care is so important for full dignity and so necessary for the proper development of life, that it is a fundamental right of every human being. This fundamental right extends across all races and ethnicities. Furthermore, this fundamental right becomes a moral obligation for health care organizations and leaders.

The following six HUMANE steps offer an innovative approach for developing cultural competence:

Step 1: Hire a diverse workforce

Hiring a diverse workforce requires a comprehensive process. Staff diversity at all levels of the organization can play an important role in meeting the needs of communities. Below are several strategies that can be employed for hiring a diverse workforce.

- Target workforce diversity as a strategic goal.
- Set diversity recruitment goals.
- Sensitize organizational leaders, managers and staff to diversity needs.
- Hire minorities for executive and managerial positions.
- Seek out minority hires from professional organizations and associations.
- Collaborate with search firms committed to diversity recruiting.

Step 2: Understand the communities served

The first step to gaining a better understanding of communities is to use the cultural climate adaptation analysis (CCAA) approach. CCAA is a two-phase approach that links environmental scanning activities with internal self-assessment.

Phase one involves an external analysis of the communities. Potential information sources include local census data, county and state health status reports, patient and consumer needs, school enrollment profiles and data from local community agencies and organizations. An action research approach is recommended. All of the communities involved in the assessment are contributing participants, making this approach informal, qualitative, formative, subjective, interpretive and reflective. Focus groups, interviews and surveys are useful, collaborative methods for gathering information.

Phase two focuses on organizational self-assessment. The Health Resources and Services Administration (HRSA) developed a product called the Organizational Cultural Competence Assessment Profile, which is useful for carrying out phase two. In general, the profile helps frame and organize the activities related to the assessment of cultural competence. The HRSA assessment profile has three major components: 1) performance areas, 2) focus areas and 3) indicators.

Within each of the performance areas, there are focus areas. HRSA describes the focus areas as the substantive topic areas used to examine for evidence of cultural competence and form the particular focus for identifying indicators. Indicators are the particular observable or measurable characteristics of an organization that signify cultural competence. The result of the assessment is organizational learning that leads to continuous service and management improvements by providing culturally related information for decision-making. These potential performance areas include:

- Organizational values;
- Governance;
- Planning and monitoring/evaluation;
- Communication;
- Staff development;
- Organizational infrastructure;
- Services/interventions.

Step 3: Make cultural competence a high priority

Commitment from leadership is the most important building block for becoming culturally competent. This level of commitment is achieved through making cultural competence a strategic initiative and by subsequently allocating resources and time to demonstrate that commitment. A key to building cultural competence is placing a high priority on leadership performance expectations. Leaders need to be “incentivized” to make cultural competence a high priority. Hospital boards need to seize the initiative and embed performance expectations in the performance management system to support their initiative. This is accomplished by establishing performance objectives and rewarding senior leaders and managers who meet or exceed performance expectations. For health care organizations serving the most diverse communities, consider the establishment of a centralized office to coordinate efforts. The office should have periodic, executive level reporting responsibilities.

Step 4: Adopt culturally and linguistically appropriate health care practices

Health care organizations that are respectful and responsive to cultural and linguistic needs will take the following actions:

- Incorporate cultural competency requirements into human resource policies, orientation programs, training programs and job descriptions.

- Make appropriate language assistance services available 24/7. Put a written policy in place and provide ongoing training on language services to staff.
- Ensure that printed materials such as patient education pamphlets and organizational newsletters reflect the different cultures. This also includes signage, pictures and posters displayed throughout the organization.
- Ensure that media resources, including the organization's website, reflect the different cultures.
- Have answering services that respond to different cultures.
- Ensure that patient and community satisfaction surveys reflect the different cultures.
- Incorporate cultural competence into performance improvement activities.
- Implement a standard format for collection of data on race, ethnicity and language. Ensure the information is included in medical records.
- Consider the use of cultural brokers. Culture brokers facilitate and mediate relationships among different cultures and can operate as cultural interpreters.

Step 5: Nurture a service-learning model

Health care organizations and leaders cannot become culturally competent solely by reading textbooks and listening to lectures. Along with reading and training, they must be educated in environments that are emblematic of the diverse society they are called to serve. The service-learning model is commonly found in the education field. Service-learning is a method that combines active collaboration with the community served, along with regular training programs. Service learning is a way for health care organizations to expose leaders and staff to ethnically and socially diverse populations, while engaging them in constructive community outreach activities. This will result in a meaningful change in the health status of your communities. Service learning provides concrete experiences and reflective opportunities, broadening health care organizations' perspectives of the communities they serve.

Step 6: Evaluate progress and continue to develop

Health care organizations should develop performance measures and conduct periodic assessments to see how the organization is doing. Phase two of CCAA serves as a tool for use in routine performance monitoring, regular quality review and improvement activities, assessment of voluntary compliance with cultural competence standards or guidelines and

periodic evaluative studies. Other culturally appropriate qualitative assessment tools should also be considered such as patient and community satisfaction surveys. Periodically, health care leaders should report organizational progress to the communities served.

Conclusion

The imperative to become culturally competent is unconditional. Meeting the health care challenges brought on by demographic changes taking place in the 21st century does not allow health care leaders to be passive bystanders in their communities, but rather insists that they ethically use all resources at their command to preserve and improve the communities served. According to Swedish (2007), a culturally competent health care organization is better able to effectively and respectfully serve patients from a rich variety of cultures, with differing ideas, experiences and perspectives. Health care leaders must be catalysts for developing culturally competent health care organizations. The six HUMANE steps provide a forward-looking approach for health care leaders to embrace.

About the Author

Phillip E. Jackson is an active duty Navy commander and is stationed at Navy Personnel Command located in Millington, Tenn. He is a fellow of the American College of Healthcare Executives. Phillip is graduating in May 2008 from Regent University, earning a Doctor of Strategic Leadership degree.

E-mail: phillip.e.jackson@navy.mil

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