

IV. CATEGORY C: ORGANIZATIONAL SUPPORTS FOR CULTURAL COMPETENCE

Little research specifically examines the processes and outcomes of organizational supports for cultural competence, although progress has been made in developing a conceptual framework that can be used to provide a foundation for research efforts. Specific literature searches were not undertaken for all categories of organizational supports. (See Appendix One for the list of search terms used.) The discussion of the literature separates groups of organizational interventions for which literature was found. For a discussion of community involvement, see *Category A: Family/Community Inclusion*.

Management, Policy and Implementation Strategies to Institutionalize Cultural Competence Activities

Several articles, focusing on the incorporation of a traditional system into a mainstream mental health system, primarily describe different approaches to implementing cultural competence activities in an organization, with very little analysis of outcomes (Giacomelli, 1997; Hagland, Sabatino, and Sherer, 1993; Ratliff, 1999; Salimbene, 1999; Stolk et al., 1998; Sublette and Trappler, 2000). Del Castillo (1999) and Agger-Gupta (2001), focusing on implementation of interpreter services in a variety of different health care organizations, both conducted dissertation research examining a variety of different factors and forces that led to successful and unsuccessful implementation of cultural competence interventions. Two studies found that health care organization policies could be crafted and improved upon when information on program needs and performance is gathered (Giacomelli, 1997; Stolk et al., 1998).

One descriptive article (Johnson and Baboila, 1996) was found on developing a cross-cultural health information system to support providers and patients with information about the cultural beliefs and practices of different ethnic communities.

Design and Use of Surveys and Profile Instruments to Plan for Services and Measure Satisfaction and Quality

As noted by Frayne and colleagues (1996), medical research often excludes people who do not speak English. Lack of research instruments that are valid and reliable with various language and cultural groups is frequently blamed. The research in this area includes reports on the testing of tools to see if they are valid and reliable, and the use of quantitative and qualitative methods to gather relevant cultural information for the purposes of survey design, pilot testing and modification of tools (Hartweg and Berbiglia, 1996; Hayes and Baker, 1998; Koseki, 1996; Morales et al., 1999; Resick et al., 1997; Simpson et al., 1994; Stanton et al., 1995).

Other Organizational/Administrative Supports Not Part of this Literature Review

Cultural Competence Self Assessments

There are a number of assessment tools for health care organizations to gauge where they are on the cultural competence continuum (Paez, 2002). No studies of the impact of cultural competence assessment could be located, but one on-going study is examining feasibility and effectiveness of implementing cultural competency assessment and training for providers as part of a systems approach to deal with culturally competent health care in a managed care setting (Dimas, 2003).

Culturally Appropriate Ethics, Conflict, and Grievance Resolution Processes

More descriptive studies are needed about the kinds of cultural issues that arise in clinical ethics, conflict, or grievance situations. Research by Kauffert and associates (1984; 1998) suggests that even well-trained interpreters who are familiar with professional standards of conduct encounter difficult cultural and ethical conflicts in the context of dealing with complex clinical situations. These situations may arise around truth-telling related to terminal diagnoses (unacceptable in many cultures). Studies are also needed on how best to prepare staff for dealing with these situations in a way that minimizes the danger to clinician-provider trust, and what institutional policies work best to support staff and patients, especially in environments where many cultures are being served.

Research Considerations

In general, considerably more information is needed to document the step-by-step processes of implementing organizational cultural competence interventions, as well as evaluations of what processes are more successful than others. Further work investigating the barriers and supports for successful implementation programs is also necessary.

Researchers should also look at whether the existence of explicit plans and strategies for implementation of cultural competence interventions facilitates and improves the delivery of those services over an ad hoc approach. Are there any organizational preconditions or critically necessary management or policy components required to accomplish outcomes?

More work is needed to determine whether the existence of such information systems results in beneficial utilization by providers and patients, and whether this information is incorporated into practice or behavior change.

Process-related considerations include best practices in providing information about cross-cultural health care and cultural competence issues for everyday use by providers and staff.

It would be useful to investigate what level of community input, data gathering and testing is necessary to develop valid tools for information gathering, as many health care organizations have neither the time nor resources to engage in complex survey development processes for the purposes of service planning and design.

The related question would investigate what kinds of information organizations need in order to develop culturally appropriate programs and systems. Finally, there is the issue of developing valid tools to gather information on patient satisfaction within programs, given the difficulty of reliably measuring satisfaction across ethnic groups.

Management, Policy and Implementation Strategies to Institutionalize Cultural Competence Activities			
Author(s)	Research Question(s)	Findings	Study Design/Methodology
Agger-Gupta N (2001)	To explore how health care organizations make the decision to implement interpreter services programs.	<ul style="list-style-type: none"> ◆ Development typically moved from a stage of “making do” without interpreters, to a “launch” stage, followed by a longer period of “normative growth and maturation” of the interpreter service. ◆ Specific catalysts created the necessary initial momentum for the organization to launch an interpreter service program, including legal, legislative and “trouble case” situations. ◆ At successful sites, the organization’s executives championed the interpreter services program. 	<p>Transcription and analysis of on-site interviews with key informants.</p> <p><u>Study Participants:</u> Health care organizations</p>
Del Castillo RR (1999)	To describe the incorporation of <i>curanderismo</i> into a public mental health system.	<p>Management strategies that were effectively implemented and resulted in the institutionalization of <i>curanderismo</i> into the mental health system, both as a treatment modality and as an educational strategy included:</p> <ul style="list-style-type: none"> ◆ Building of a solid infrastructure to support alternative mental health programming. ◆ Demonstration of effective leadership. ◆ Strong minority voice. Introduction of intermediaries. 	<p>Descriptive</p> <p><u>Target Population:</u> Hispanic mental health patients</p>
Giacommelli J (1997)	To review the use of health interpreter services as part of a total quality management (TQM) approach.	<ul style="list-style-type: none"> ◆ There was a marked tendency by staff to use non-accredited interpreters. ◆ Staff who used non-accredited interpreters tended to inappropriately assess patient/client interpreting needs and to be unfamiliar with the Health Care Interpreter Policy. ◆ The TQM team subsequently devised several strategies for change. 	<p>Survey</p> <p><u>Study Participants:</u> Staff at health care organization</p>

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Author(s)	Research Question(s)	Findings	Study Design/Methodology
Hagland MM, Sabatino F, Sherer JL (1993)	To describe challenges hospitals face in serving multicultural patients.	<ul style="list-style-type: none"> ◆ Language and cultural differences must both be addressed. ◆ Medical interpreters can serve as cultural brokers. ◆ Some hospitals have set up services specifically for foreign patients. 	<p>Descriptive</p> <p><u>Target Population:</u> Hospitals</p>
Johnson AE, Baboila GV (1996)	To describe the integration of a health information system to meet the needs of providers and patients.	<ul style="list-style-type: none"> ◆ Ethnographic research is used to develop mechanisms for health systems improvements, including a computer-based health information system, brown-bag seminars, and cross-cultural skills training. 	<p>Descriptive</p> <p><u>Study Participant:</u> Hospital</p>
Ratliff SS (1999)	To describe the development of diversity awareness at Children's Hospital in Columbus Ohio.	<ul style="list-style-type: none"> ◆ Describes the integration of administrative and individual initiatives aimed at institutionalizing cultural competence into a hospital system. ◆ A range of efforts are described including international exchange programs to language classes. 	<p>Descriptive</p> <p><u>Study Participant:</u> Hospital</p>
Salimbene S (1999)	To describe the culture-health care relationship and 10 indicators for measuring cultural competence.	<ul style="list-style-type: none"> ◆ Offers a practical, system-wide model for the improvement of nursing care quality through enhanced cultural competency and lists resources that can assist with the integration of cultural competence into health care systems. 	<p>Descriptive</p> <p><u>Target Population:</u> Nurses</p>
Stolk Y, Ziguras S, Saunders T, Garlick R, Stuart G, Coffey G (1998)	To determine the effectiveness of a training and policy strategy to improve communication opportunities in an acute inpatient unit for patients of non-English-speaking background with low English proficiency.	<ul style="list-style-type: none"> ◆ 33% of admissions were from non-English-speaking backgrounds. ◆ Of the 11 languages spoken by patients, 7 were spoken by staff members. ◆ 29% were not clinically proficient in these languages. ◆ Following the intervention, interpreter bookings and booking duration increased significantly. ◆ Standard training packages and policy promoting interpreter use improved communication opportunities. 	<p>Pre-/post-test</p> <p><u>Study Participants:</u> Patients from non-English-speaking backgrounds and clinical staff</p>

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Author(s)	Research Question(s)	Findings	Study Design/Methodology
Sublette E, Trappler B (2000)	To examine cultural and religious issues arising in the treatment of Orthodox Jewish inpatients and describes the integration of religious practices into policies and procedures.	<ul style="list-style-type: none"> ◆ Cultural and religious practices of Orthodox Jewish inpatients were accommodated by a health care system. ◆ Cross-cultural therapeutic goals included the integration of non-medical- compromising religious practices, increasing the cultural sensitivity of medical staff through training and understanding the role of religion in patient-provider communication. 	<p>Descriptive</p> <p><u>Study Participant:</u> Hospital</p>
Design and Use of Surveys and Profile Instruments to Plan for Services, and Measure Satisfaction and Quality			
Author(s)	Research Question(s)	Findings	Study Design/Methodology
Frayne SM, Burns RB, Hardt EJ, Rosen AK, Moskowitz MA (1996)	To determine how often non-English-speaking (NES) persons are excluded from medical research.	<ul style="list-style-type: none"> ◆ 22% of research investigations included NES persons. ◆ 16% had not considered the issue. ◆ 32% thought inclusion affected their study results. <p>Of the studies that excluded NES persons (40% of the sample):</p> <ul style="list-style-type: none"> ◆ 51% had not thought of the issue. ◆ Translation issues and recruitment of bilingual staff were frequently cited. ◆ 35% indicated that no NES persons resided in study area. ◆ Exclusion of NES persons from research may limit the generalizability of research findings. 	<p>Survey</p> <p><u>Study Participants:</u> Investigations on provider-patient relations published in major U.S. journals</p>
Hartweg DL, Berbiglia, VA (1996)	To determine whether one part of the Health Promotion Self-Care Interview Guide (HPSCIG), developed to identify self-care actions that promote well-being in healthy, middle-aged Anglo-American and African American women was culturally sensitive for use with Mexican American women.	<ul style="list-style-type: none"> ◆ The findings support the use of the HPSCIG with healthy, middle-aged Mexican American women. 	<p>Analysis of congruence and relevance</p> <p><u>Target Population:</u> Mexican American women</p>

Design and Use of Surveys and Profile Instruments to Plan for Services, and Measure Satisfaction and Quality			
Author(s)	Research Question(s)	Findings	Study Design/Methodology
Hayes RP, Baker DW (1998)	To determine the validity and reliability of English and Spanish versions of a patient satisfaction measure Interpersonal Aspects of Care (IAC) Examiner Scale.	<ul style="list-style-type: none"> ◆ The IAC scale was reliable and valid. ◆ The Spanish version was found to be significantly less reliable and valid. ◆ Significant differences between Spanish- and English-speaking patients were found in the majority of individual scale items. ◆ Spanish-speaking patients tended to respond "good" more often than English speakers. 	<p>Analysis of reliability and validity coefficients</p> <p><u>Study Participants:</u> English- and Spanish-speaking patients</p>
Koseki LK (1996)	To describe the self-administered survey process used to obtain data describing utilization and satisfaction patterns of Native Hawaiian elders with the <i>Good Health and Living for the Elderly</i> project.	<ul style="list-style-type: none"> ◆ Integration of community in the design and implementation of research increases the likelihood of a culturally appropriate assessment tool and increased response rate. 	<p>Descriptive</p> <p><u>Study Participants:</u> Native Hawaiian elders</p>
Morales LS, Cunningham WE, Brown JA, Liv H, Hays RD (1999)	To examine the association of patient ratings of provider communication with patient language and ethnicity.	<ul style="list-style-type: none"> ◆ Latinos responding in Spanish were significantly more dissatisfied compared with those responding in English, or whites responding in English when asked whether medical staff listened to what they say, answered their questions and gave explanations about prescribed medications, explanations about medical procedures and test results, and reassurances and support from their doctors and office staff. 	<p>Survey</p> <p><u>Study Participants:</u> Patients receiving medical care</p>
Resick LK, Taylor CA, Carroll TL, D'Antonio JA, de Chesnay M (1997)	To describe the integration of a nurse-managed clinic in a predominantly African American apartment building.	<ul style="list-style-type: none"> ◆ Describes the benefits of establishing a clinic in an apartment building whose residents were predominantly elderly African Americans. ◆ Ethnographic research was used to ensure service delivery was culturally competent. ◆ Providing comprehensive services through an outreach-based extension of the system, not only benefits consumers, but also provides clinicians and students with community-focused experiential training. 	<p>Descriptive</p> <p><u>Study Participant:</u> Nurse-managed clinic in a predominantly African American apartment building</p>

Design and Use of Surveys and Profile Instruments to Plan for Services, and Measure Satisfaction and Quality			
Author(s)	Research Question(s)	Findings	Study Design/Methodology
Simpson E, Gawron T, Mull D, Walker AP (1994)	To describe the development and evaluation of a Spanish-language prenatal Family Health Evaluation questionnaire.	<ul style="list-style-type: none"> ♦ The Family Health Evaluation aimed to elicit risk factors, to increase clients' knowledge about reproductive choices, and to improve access to genetic services. ♦ Data collected during the pilot study phase of the process indicated that the questionnaire is effective in identifying additional family information needs about medical conditions, counselling, etc. 	Descriptive <u>Target Population:</u> Hispanic women
Stanton B, Black M, Feigelman S, Ricardo I, Galbraith J, Li X, Kaljee L, Keane V, Nesbitt R (1995)	To describe the process of creating a culturally and developmentally appropriate data-gathering instrument for use in monitoring the impact of an AIDS educational intervention on the health outcomes of urban African American pre-adolescents and early adolescents.	Describes three phases of a culturally appropriate survey design for minority populations: <ul style="list-style-type: none"> ♦ Ethnographic research (participant observation, focus groups, individual interviews). ♦ Construction and pilot testing of instrument. ♦ Finalization, including reliability testing. 	Descriptive <u>Target Population:</u> African American adolescents
Other Organizational/Administrative Supports Not Part of This Literature Review: Cultural Competence Self Assessment, and Culturally Appropriate Ethics, Conflict, and Grievance Resolution Processes			
Author(s)	Research Question(s)	Findings	Study Design/Methodology
Dimas JM (2003)	To examine the feasibility and effectiveness of implementing cultural competency assessment and training for providers as part of a systems approach to deal with culturally competent health care in a managed care setting.	This project is in progress.	Descriptive <u>Study Participant:</u> Managed care plan
Kaufert JM, Koolage WW (1984)	To examine the role conflicts experienced by Cree and Saulteau language speaking interpreters working in 2 urban tertiary medical care centers in Canada.	<ul style="list-style-type: none"> ♦ Describes 4,000 videotaped clinical consultations in which an inventory of roles and situations characterized the work of interpreters. ♦ Sources of role conflict were associated with cross-pressures in their work as language interpreters, culture brokers and patient advocates. 	Analysis of videotaped sessions <u>Study Participants:</u> Cree and Saulteau language speaking interpreters

Other Organizational/Administrative Supports Not Part of This Literature Review: Cultural Competence Self Assessment, and Culturally Appropriate Ethics, Conflict, and Grievance Resolution Processes			
Author(s)	Research Question(s)	Findings	Study Design/Methodology
Kaufert JM, Putsch RW, Lavalley M (1998)	To examine the experience of Aboriginal medical interpreters working with terminally ill patients, family members and providers.	<ul style="list-style-type: none"> ♦ Analysis focuses on the cultural dimension of value conflict situations, particularly in relation to issues of individual autonomy and biomedical emphasis on truth-telling in the communication of terminal prognosis. 	Qualitative observational analysis <u>Study Participants:</u> Medical interpreters
Paez K (2002)	To assist health plans in: 1) assessing the diversity of their population and their current level of cultural and linguistic competence, 2) identifying feasible priority areas for improvement of culturally and linguistically appropriate services (CLAS) based on the assessment, and 3) developing a plan to implement cost-effective and manageable interventions.	<ul style="list-style-type: none"> ♦ Addresses four aspects of the assessment process: 1) preparing the CLAS Assessment and Planning Team, 2) assessing the diversity of members and the community, 3) assessing the managed care plan, and 4) identifying gaps, determining priorities, and briefing senior leaders. ♦ Offers an overview of three areas of concentration for improving CLAS: 1) providing linguistic services (oral and written), 2) improving cultural competence, and 3) developing a diverse workforce. ♦ Appendices include reprints of cultural competence assessment tools. 	Guide <u>Target Population:</u> Health care organizations

