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Cultural Competency in the Health Care System:
Critical Review and Survey of California's Managed Care Organizations

by

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Preface

This paper is divided into an introduction and four chapters. Its purpose is to provide a framework for understanding the present state of theory, research, and interventions in the health care community which relate to the concept of *cultural competency*. It will begin with an introduction that will briefly trace the historical lines of various efforts which have, to a large extent, converged in the formation of this conceptual and applied construct. Hopefully, this will begin to provide a more tangible definition of cultural competency.

In the first and second chapters, the theoretical foundations of what is currently referred to as culturally competent health care will be discussed in more detail. The concept of cultural competency will be examined two levels: the level of the individual practitioner-patient interaction and the level of the community-based organization. At each of these levels, the paper will first trace, from an historical and critical perspective, the theoretical sources of interventions which have been proposed for beginning to achieve cultural competency in the health care system. It will then discuss examples of projects which have implemented these theoretical models experimentally and/or interventionally. Next, it will summarize and discuss sources in the health care literature which have accumulated in recent and past years regarding the evaluation of such programs. In addition, the paper will attempt to address the broader political, economic, and inter-professional factors which have contributed to cooperation, competition, and resistance within and between various sectors of the academic and health care communities.

In the third chapter, the paper will move on to discuss the emergence of concepts of cultural competency at the levels of health care administration, health care research, and health care policy. In so doing, its orientation will shift away from the more theoretical and experimental aspects of the development of the concept of culturally

competent health care. Instead it will examine the ways in which concepts of culturally competent care that were developed at the individual patient-practitioner and community-based organization levels are now being fused and integrated with other concepts to create approaches for addressing issues of cultural diversity within broader realms. It will examine some of the implications of this process for public and private institutions, for disciplines of academic research, and for entire health care systems. It will also identify some of the major obstacles and limitations of this process in these areas.

In the fourth chapter, the paper will provide an example of a research project which attempts to bridge some of the gaps which currently exist between the various theories, interventions, and policies of culturally competent health care. The project consists of a survey of managed health care institutions in California, which was designed to assess the prevalence, among these institutions, of policies, structures, and practices which have been defined within the concept of culturally competent health care. Aspects of the project's development, implementation, and its results will be discussed with respect to both their immediate significance and in terms of their broader relevance to future efforts to further integrate concepts of culturally competent health care.

Introduction and Background

Cultural competency is a term which is encountered frequently in current mainstream health care discourse. From a brief review of medical and health care related literature, one finds that there has been a rapid proliferation of interest in the subject in the last decade. Furthermore, one finds that this interest is not necessarily limited to any particular sector of the health care community. The topic of culturally competent care is pursued intensively by academic researchers, health care administrators, and clinical practitioners alike. While there are obviously significant differences in the motivations between groups for promoting and investigating the topic, and indeed there is considerable incongruity between the definitions which various individuals have adopted as constituting cultural competency, an underlying assumption which all share is that culture and health are directly influenced by one another in tangible ways. Furthermore, to varying degrees, they all share the principle that mainstream Western health care can be modified to provide appropriate and responsive care to cultural minority groups.

In part, this phenomenon is a natural by product of the larger movement over the past twenty years to connect culture and health. The emergence of this largely academic movement is well documented, and is perhaps best demonstrated by the explosion of interest in the field of medical anthropology. With the realization that there are intrinsic and, more importantly, extractable associations between culture and health, there has been a natural progression to efforts at organizing and systematizing approaches to improve health vis-à-vis culture. The result has been the synthesis of numerous models that attempt to improve health through culture at various levels. Historically, these models have been the product of work in many disciplines, with varying methods and standards in design and evaluation. The resulting lack of coordination or consistency between these applied models has provided the impetus for constructing a vehicle for

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integrating the disparate strains. It can be argued that this vehicle has been found, in large part, in the concept of cultural competency.

Nonetheless, because cultural competency includes such an amalgam of diverse models, its specific definitions and means of implementation have been sources of considerable controversy. In addition, because it is an inherently applied concept, these definitions and means of implementation potentially have broad implications for many sectors of the health care community. Furthermore, another major impetus for the growing interest in the discourse on cultural competency, which is less often discussed openly, is inter- and intra-professional self interest. Such self interests are no doubt amplified by the current state of flux within the health care system in general, which provides a backdrop of competition that is very often fueled by economic and political motivations rather than on broader social agendas. While the use of cultural competency and related concepts as implements for forwarding political and economic agendas is a topic rarely discussed directly in the current health care dialogue, this paper will attempt to extract the salient components of these sub-textual influences.

The theoretical roots of what is now referred to as culturally competent health care can be traced back at least to the middle 1970s. During this period, a number of major groundbreaking works emerged from various health care related academic disciplines, exploring fundamental elements of the interface between culture and health care provision. At least three relatively distinct, although certainly not mutually exclusive, academic strains coexisted and occasionally converged in creating the area of theoretical and applied knowledge which was most frequently referred to as either "transcultural care" or "cross-cultural care." These strains included: 1) a modest dialogue emerging from within the professional ranks of the health care system itself, with the most prominent among these being clinical nursing and psychiatry; 2) a rapidly expanding body of work produced primarily by medical anthropologists, which viewed the lack of attention to the culture-health interface in the present medical system as a

central object for criticizing and revising clinical medical practice; and 3) research and policy interventions implemented by sectors of the public health and related social service communities concerned with culture because of its implications for correcting, or at least addressing, issues of social injustice in health access and utilization. In addition to work from these major strains, there has also been considerable work contributed to the subject from other, perhaps less health care related fields, ranging from linguistics to business administration. Indeed, cultural competency is a subject with implications which extend far beyond the realm of health care provision.

Work on transcultural care which emerged from within the health care professions themselves in the 1970s was, not surprisingly, directed primarily at transforming clinical practice, and not the structure of the health care system, per se. A common message in much of this literature was that Western medical care had to adapt to social and cultural variations if it was to effectively penetrate into disease treatment on a global scale. Methods proposed in this area for modifying the practitioner-patient interaction tended to seek universally applicable approaches for understanding the influence of culture on the clinical encounter. Madeline Leininger, the most prominent and active health care professional in this area during this period, described a "transcultural health model," outlining a generic, multi-level approach to studying and analyzing health care systems. The model called for the synthesis of a "transcultural health worker," whose job would essentially consist of implementing a taxonomic approach to the study of non-Western health systems from a "holistic" perspective. This perspective would attempt to take into consideration various sociodemographic and political influences.[1]

In fact, the work of Leininger's "transcultural health worker" was simultaneously being proposed by many individuals in the newly emerging field of medical anthropology

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[1]Leininger, MM. Transcultural Health Care Issues and Conditions, Philadelphia, F. A. Davis Co, 1976, pp. 17-21.

(although such work was being discussed almost completely independently of any influence by Leininger). In the 1970s, this relatively unexplored field was appealing to many individuals who wanted to challenge and revise the present practice of medicine, and was expanding at a very rapid pace. C.H. Browner has summarized the aspirations of medical anthropology at that time as: 1) to create new understandings of the fundamental nature of health and illness, 2) to reduce worldwide tolls of disease, disability, and human suffering, and 3) to find a permanent place within the medical establishment.[2] However, while the theory of medical anthropology may have been largely revisionist, the specific research of many medical anthropologists was often disconnected from the health care system itself. In fact, much of the medical anthropology of the period was devoted to academically grounded studies of culture and health, which resulted in the production of a large body of typological work. This work was subjected to criticism for its lack of significant direct utility in the clinical setting. Borrowing the terminology of Wilbert Gesler, the bulk of medical anthropology focused on understanding *humanistic landscapes* rather than on comprehending the more clinically applicable *structuralist landscapes*.[3]

Into this backdrop, Arthur Kleinman began to publish a number of widely discussed works in the late 1970s and early 1980s. Kleinman, a physician-anthropologist who was strongly influenced by George Engler's biopsychosocial conception of medicine, provided a model for understanding the interface between culture, illness, and disease which, unlike the work of many of his peers, was directed largely at creating approaches to revise clinical practice. In his model, medical systems were cultural systems and, as such, any clinical interaction was cross-cultural. Kleinman, like Leininger, sought universal principles of cultural systems, and he

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[2]Browner, CH, Ortiz de Montellano, BD, and Rubel, AJ. "A methodology for cross-cultural ethnomedical research," Current Anthropology, 29(5), 1988, p. 681.
[3]Gesler, WM. "Therapeutic landscapes: Medical issues in the light of the new cultural geography," Social Science and Medicine, 34(7), 1992, pp. 735-46.

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provided a theoretical mechanism by which health could be improved at the

practitioner-patient level. The core of Kleinman's model was the distinction between

illness and disease as alternative "explanatory models" of sickness.[4] Illness was the

experience of sickness, whereas disease was Western medicine's interpretation of

sickness as an anatomic-physiologic dysfunctioning of the body. To briefly paraphrase

Kleinman's conclusions, it was the attempt to equate illness and disease which

produced Western medicine's failure to provide adequate cross-cultural care in the

clinical setting. The solution to this deficiency seemed relatively straightforward to

Kleinman and those who subscribed to his model: clinician's could be trained to

negotiate differences between the patient's model of sickness and their own.[5] Medical

anthropologists would presumably provide guidance in this training and would continue

to pursue research along these lines.

In fact, the approaches presented by medical anthropologists and health care

professionals in the mid- and late-1970s for bridging cultural gaps in health care would

prove far less than straightforward. Much of the difficulty in moving from theory to

practice was the by product of an inherent tension between abstracting *cultural influences*

on health care (the primary goal of medical anthropology) and understanding the

significance of such abstractions to the *behavior of the individual*.[6] In addition, the

obstacles entailed in creating a place for the anthropologist within the bureaucracy of the

medical system proved a major challenge. While numerous researchers and clinicians

would continue to pursue these approaches, some with considerable success, the focus

on efforts at the clinical level in isolation from the much broader influences of culture on

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[4]Kleinman, A. "Concepts and a model for the comparison of medical systems as cultural systems," Social Science and Medicine, 12, 1978, pp. 88-89.
[5]Kleinman, A, Eisenberg, L, and Good, B. "Culture, illness and care: Clinical lessons from anthropologic and cross-cultural research," Annals of Internal Medicine, 88, 1978, pp. 251-8.
[6]Like, R and Steiner, R. "Medical Anthropology and the Family Physician," Family Medicine, 18(2), 1986, p. 88.

health was perhaps far too idealistic. It is in contrast to this idealism that the third strain of work in the area of cross-cultural health care becomes significant.

Emerging out of the late 1960s, a growing literature of work began to focus upon the issue of racial disparity in health attainment and provision in the United States. In the social sciences, including the disciplines of public health, social welfare, and mental health, discourse was increasingly directed at social injustice--whether its etiology be racial, economic, or both--as the source of well documented inequities in access to adequate health care. While the rhetoric of this movement took the form of racial and social inequity discussions, the specific research in this area tended to be highly pragmatic. Fueled by significant public and private funding, a large body of epidemiologic research emerged to provide evidence for the possible sources of disparities in access to health services. Furthermore, this research provided the foundation for a growing discourse on larger health planning issues for reaching the underserved. As a result, there was a rapid proliferation of proposals for, and pilot investigations studying the application of, specific interventions to improve access to health care for ethnic and cultural minorities. As the number of such interventions grew, a subset of them started to become accepted under a new terminology which focused problems of access on the cultural incompatibility of the health care system for certain minority groups. The nature of this terminology was clearly more politically motivated than the cross-cultural/transcultural terminology introduced by Leininger, Kleinman, and others.

The emergence, in health related literature of the mid 1970s through the 1980s, of terms such as *culturally sensitive, culturally appropriate*, and *culturally responsive* represented an active attempt to emphasize the existence of a spectrum of accomplishment in the provision of care to culturally varied populations. The implication of using such terminology was that, in this spectrum, the status quo of the health care system generally did not reflect the definitions of these terms. In other

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words, the traditional approach of Western health care systems, particularly that in the United States, was culturally *in*sensitive, culturally *in*appropriate, and culturally *un*responsive.

As efforts to take on the disparity in health status of ethnic and cultural minorities continued to proliferate, the unregulated use of such terminology became increasingly problematic. As one observer noted, "'culturally appropriate' treatment often becomes a generalized application of bits and pieces from the social science literature and the media, and a memory bank of learned stereotypes. In some cases, this application of undifferentiated information may be as damaging as cultural insensitivity."[7] The often ambiguous application of terms such as culturally sensitive care, culturally appropriate care, and others reflected a need for a detailed reformulation of the general and specific meanings of this new language.

To a large degree, this definition was found in the introduction, in the mid- to late-1980s of the concept of *culturally competent care*. In 1989, Terry Cross and his co-workers published a labor intensive monograph which has, to date, remained the most comprehensive effort to define cultural competency. In the work of Cross, et al., culturally competent care became a sort of umbrella concept to include all efforts to address health access issues by first addressing issues of cultural difference. The work of Cross, et al. provided a number of approaches for defining cultural competency. First, their work provided a generalized definition of culturally competent care which would at the same time supersede and include other terminologies such as culturally sensitive, culturally appropriate, etc. Second, their work outlined an approach which defined culturally competent care at four levels: the consumer level, the individual practitioner level, the administrative level, and the policy-making level. Third, their

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[7]Bestman, E. "Cross-cultural approaches to service delivery to ethnic minorities: The Miami model," in <u>Mental Health Research and Practice in Minority Communites: Development of Culturally Sensitive Training Programs</u>, eds. Miranda, M and Kitano, H, Rockville, MD, National Institute of Mental Health, 1986, pp. 199-226.

work offered a definition of culturally competent care which followed a continuum model, in which six progressive stages were proposed for determining the degree to which an individual, organization, or system was equipped to serve culturally diverse populations: 1) *cultural destructiveness*, 2) *cultural incapacity*, 3) *cultural blindness*, 4) *cultural pre-competence*, 5) *cultural competence*, and 6) *cultural proficiency*. Fourth, their work provided an initial framework of specific criteria for defining cultural competency at the four levels which they proposed.[8] These criteria were developed, for the most part, through comprehensively surveying relevant theories and interventions which had been presented in the social science and health care literature under the rubric culturally competent care over the previous decade-and-a-half.

In the half-decade since the work of Cross, et al. was published, there have been no efforts to engage in a comprehensive review of the literature on culturally competent health care. This is significant, given that the use of the term culturally competent has grown exponentially during this period, and that the diversity of contexts in which terms such as culturally competent, culturally sensitive, culturally appropriate, etc. are now being utilized is unprecedented. As concepts of culturally competent care are expanded into new sectors of the health care community, the definitions of such care are continuously being transformed. However, this dynamic process is by no means an inherently rational one. Indeed, the gulf between theory and practice in the realm of culturally competent care is considerable. The following three chapters will attempt to review, in as comprehensive a manner as possible, the current dialogue which is driving this process. In addition, every effort will be made to identify the various players involved in shaping this discourse and to infer some of the intrinsic professional, political, and economic forces influencing these participants in pursing their work.

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[8]Cross, T, et al. Towards a Culturally Competent System of Care, Volume I, Washington, DC, Georgetown University Child Development Center, 1989.

Chapter I: The Patient-Practitioner Level

In the development of concepts of culturally competent care at the individual patient-health care practitioner level, there has generally been a predominance of theory over practice. Much of the theory in this area is firmly rooted in anthropological definitions of culture, illness, and health, which have been the impetus for a vast body of medical anthropological research. It is beyond the scope of this paper to explore these foundations comprehensively. Instead, the discussion in this chapter will emphasize those theoretical strains which have been most relevant to clinical practice. In addition, this discussion will, whenever possible, avoid aspects of theory and practice which have evolved from health care contexts outside of the United States.

Theoretical Basis of Interventions:

At the level of the patient-practitioner interaction, a number of clinically applicable strategies have emerged under the heading of cultural competency or similar terminology. The greatest number of these approaches have their direct theoretical basis in the work of either Kleinman, Leininger, or both. These approaches have embraced the holistic, biopsychosocial concept of health care, emphasizing the importance of communication and empathy, as well as sensitivity to variables relating to cultural difference, on the part of individual providers. While there have been numerous names attached to variations on Kleinman's and Leininger's models, including *cultural/transcultural care*,[9] *the ethnic/cultural systems model*,[10] *the cultural bridge model*,[11] *cross-cultural ethnomedicine*,[12] *the anthropology of family medicine*,[13] *the culturally competent*

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[9]Henderson, G and Primeaux, M. <u>Transcultural Health Care</u>, Menlo Park, CA, Addison-Wesley Pub. Co., Medical/Nursing Division, 1981; Leininger, MM. <u>Transcultural Health Care Issues and Conditions</u>.
[10]Orque, M. "Orque's ethnic/cultural system: A framework for ethnic nursing care," in eds. Orque, M and Bloch, B, <u>Ethnic Nursing Care: A Multicultural Approach</u>, St. Louis, Mosby, 1983.
[11]West, E. "The cultural bridge model," <u>Nursing Outlook</u>, 41(5), 1993, pp. 229-34.
[12]Browner, Montellano, and Rubel.
[13]Like and Steiner, p. 87.

model of care,[14] as well as others, these approaches have all been fairly similar in content. Indeed, their various titles are likely more reflective of a backdrop of inter- and intra-professional hegemony and non-communication. A common thread through such models is frequent reference to the concept of two parallel perspectives of health and illness, the *etic* (cultural outsider perspective) and the *emic* (cultural insider perspective), which shape the quality of communication of any clinical encounter. In summarizing these models, the goal for individual practitioners seeking to become culturally competent is the following: 1) develop an acknowledgment of the patient's (emic) conception of the health problem, 2) appreciate the influence of the practitioner's own (etic) conception, 3) consider the way in which these culturally informed differences in perspective influence patient-practitioner communication, and use such knowledge to minimize the destructive aspects of such differences.[15] Leininger has referred to this last step as "culturalogical assessment."[16]

In these models, the presumed foundation for clinicians to begin to achieve progressive levels of cultural competency, acknowledging and understanding the influence of the emic perspective on conceptions of illness and disease, is the large body of descriptive work compiled by anthropologists (and a minority of other researchers) in the past twenty or so years. However, sources for such descriptive work on the general and specific health beliefs and behaviors of different cultural groups have been vast and variable, and consensus in the basic content and underlying intent of such work has never been obtained. Indeed, among medical anthropologists themselves, there has been considerable debate regarding the fundamental purpose of such work within their field. For example, some researchers have attempted to provide more clinically accessible

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[14]Campinha-Bacote, J. "Cultural competence in psychiatric mental health nursing. A conceptual model," The Nursing Clinics of North America, 29 (1), 1994, pp. 1-8.
[15]Cross, et al., pp. 32-35.
[16]Leininger, MM. "Culturalogical assessment domains for nursing practice," in ed. Leininger, MM, Transcultural Nursing: Concepts, Theories, and Practice, New York, John Wiley and Sons, 1978, pp. 85-106.

information by typifying and summarizing characteristic patterns of health behaviors and beliefs among various cultural groups, for the use of individual practitioners. Others have insisted that such "thumbnail" descriptions ultimately detract from the goal of understanding the influences of culture on health beliefs and behaviors, as they tend to "romanticize,"[17] as well as stereotype, the health beliefs of cultural minorities. The result has, to a large extent, been ambiguity regarding the specific role of the clinician in mediating cross-cultural interactions.

In addition to the problem of inconsistency in the approaches of descriptive cross-cultural health typologies which have emerged, other points of criticism can be directed at models which attempt to focus exclusively on the idealized cultural watershed between clinical providers and their patients. One potent criticism is that these models typically ignore or inadequately address broader politico-economic influences on the cultural divide between individual providers and patients. Such critics tend to hail from the school of thought known as *critical* medical anthropology—to be distinguished from Kleinman's following of *clinical* medical anthropologists. They emphasize that while physicians and other clinicians may exert considerable control over individual clinical encounters, these encounters are almost always directly and indirectly influenced by bureaucratic and political factors which are not taken into consideration by most of these models.[18] Because of this shortcoming of clinical anthropology's models, they argue that the role of the clinical practitioner becomes merely one of "patching" the symptoms of broader social and economic forces, without actually confronting them directly.[19] Furthermore, they argue that an integration of their critical, research oriented approach with the clinical, professionalized, approach may be

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[17]Phillips, MR. "Can 'clinically applied anthropology' survive in medical care settings?" Medical Anthropology Quarterly, 16, 1985, p. 34.
[18]Baer, HA, Singer, M, and Johnsen, J. "Toward a critical medical anthropology," Social Science and Medicine, 23(2), 1986, pp. 95-8; Janzen, J. "The comparative study of medical systems as changing social systems," Social Science and Medicine, 12, 1978, pp. 121-9.
[19]Baer, HA. "How critical can clinical anthropology be?" Medical Anthropology, 15(3), 1993, pp. 299-317.

impossible, as political structures and territoriality within the health care system make these goals incompatible.[20] In response to such criticism, Irwin Press has countered that the effectiveness of clinical anthropology's focus upon the "micro-level" processes of health provision is already well documented and it is, in fact, the critical anthropological approach which needs to establish its relevance within the American medical system.[21] Needless to say, debates between clinical and critical anthropologists will continue.

Another problem regarding the theoretical foundations for approaches aimed at modifying patient-practitioner interactions around issues of culture is the frequent redundancy of theoretical models in different segments of the health care literature. Such redundancy often results in incompatibility in language when comparing one model to another. This problem is most apparent between different academic and professional disciplines. For example, Leininger's transcultural model for clinical nursing, which holds many similarities to Kleinman's model (and, in fact, preceded it in time of publication) is almost never referred to in the medical anthropology literature. Examples of redundancy such as this are perhaps not surprising given the very different goals of each of these disciplines and political aspects of their inter-professional relations. However, it has also been found to be present between the work of various researchers within individual disciplines. For example, a recent meeting of a panel of academic nursing experts regarding issues of cross-cultural care concluded that one of its highest priorities was to overcome "constraints in comparative research and theory related to culturally competent care because of lack of common language among nurses focused on cross cultural care."[22]

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[20]Ibid.; Baer, HA. "The possibilities and dilemmas of building bridges between critical medical anthropology and clinical anthropology: A discussion," Social Science and Medicine, 30(9), 1990, pp. 1011-3.
[21]Press, I. "Levels of explanation and cautions for a critical clinical anthropology," Social Science and Medicine, 30(9), 1990, pp. 1001-9.
[22] "AAN Expert Panel Report. Culturally competent health care," Nursing Outlook, 40(6), 1992, pp. 277-83.

An additional point which makes many of these models problematic is the assumption that practitioners can be trained to empathize with patients of cultural minority groups in a fairly universal fashion. In other words, most of these models require that clinicians have the capacity to learn to abstract from generalized descriptions of the health beliefs and behaviors of particular cultural minority groups to individual patients. The source for this education is, in most of these models, the clinical anthropologist or his/her equivalent. A theoretical problem with this approach which has been raised by a number of individuals, including clinical anthropologists themselves, is that political factors within the traditional structural hierarchy of the health care system make these strategies difficult to implement.[23] The handful of published evaluations of programs which have been implemented to educate clinicians to become more culturally competent is discussed below.

Given such limitations at the conceptual level for directly modifying the individual practitioner's approach to treating cultural minority patients, other theoretical models have been developed with the goal of improving cultural competency at the practitioner-patient level, which do not rely exclusively upon directly improving the cross-cultural skills of practitioners themselves. These models call for the creation of positions within the health care system for individuals who are, essentially, specialists in cultural knowledge. The most prominently discussed among these prototypical "culture specialists" are the *culture broker* and the *lay health advisor*. Both are derived from a concept introduced by Eric Wolf, a medical anthropologists studying aspects of Mexican society in the mid-1950s, who focused upon the role of middlemen in negotiating between groups at local and national levels.[24] However, while some sources in the literature continue to refer to these conceptual health care workers almost interchangeably, the historical evolution of each follows a separate path.

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[23]Phillips, pp. 31, 34.
[24]Wolf, E. "Aspects of group relations in a complex society; Mexico," <u>American Anthropologist</u>, 58, 1956, pp. 1065-78.

The current concept of the culture broker is very closely associated with clinical medical anthropology. Its lineage is essentially the same as that which formed the framework of holistic medicine that has produced the models for directly affecting the cross-cultural capacities of clinical providers discussed above. Indeed, many of these models include culture brokers as integral sub-components. Philip Dennis provides a generalized definition of a culture broker as "someone competent in two cultures and languages, who can relate two different groups to each other."[25] While some sources have taken this definition to include, and even emphasize, those individuals from outside of the health care system who are members of cultural minority groups and knowledgeable of their respective cultures, this is not the approach which is generally taken within academic literature. In order to be consistent with Kleinman's model, in which the health care system is in itself a cultural system, a culture broker is usually defined as an individual who is competent in his/her knowledge of both the culture of a particular minority group (or set of groups) *and* the culture of the health care system itself. Hence, the culture broker is typically an individual who is either a member of the health care system or some other professional allied with the health care system. This is the definition which will be used in this paper.

The two fields which have most vigorously pursued the conceptualization (and implementation) of the culture broker model are clinical anthropology and clinical nursing. Clinical and academic nurses have tended to view culture brokerage, the act of "bridging, negotiating, or linking the orthodox health care systems with clients of different cultures,"[26] as a logical extension of their existing professional role. Toni Tripp-Reimer and Pamela Brink, who have been prominent in developing the concept of the nurse as culture broker, outline a model in which culture brokerage is but one role among many which the nurse plays. Therefore the activity is presumably integrated with

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[25]Dennis, PA. "The life of a culture broker," Human Organization, 53(3), 1994, p. 303.
Tripp-Reimer, T. "Culture brokerage," in Nursing Interventions: Treatments for Nursing Diagnoses, eds. Bulecheck, G and McCloskey, J, Philadelphia, Saunders, 1985, p. 352.

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the more traditional aspects of the profession. They distinguish this role from that of clinical anthropology's description of a "full time" culture broker, in which, they argue, the culture broker actually has political (employment-oriented) motivations for maintaining barriers between the health care system and cultural minority groups.[27] An obvious criticism which can be made of this integrated culture broker model, however, is that it, like models which do not specifically call for the creation of a "cultural specialist," produces a great degree of ambiguity as to what the specific functions the nurse-culture broker is to play.

As a result, others in the profession have been compelled to offer conceptual solutions for reducing this ambiguity. For example, Mary Ann Jezewski, attempting to specify the capacity in which the nurse is to act as a culture broker, outlines a model in which the culture broker role is placed under the larger umbrella of the nurse's role as *patient advocate*.[28] Diverging more radically from the integrated nurse-culture broker model, Madeline Leininger has recently discussed the role of the "transcultural nurse specialist." This certified individual is trained as an expert in knowledge of the health beliefs and behaviors of particular cultural minority groups, and serves as a clinical consultant as well as a nursing educator. Leininger's primary rationale for promoting further specialization of nurse-culture brokers is the argument that general clinical nursing has recently been overextended into an array of new roles.[29]

It is important to note that the general description of the role of this transcultural nurse specialist is, in almost all respects, synonymous with that of the culture broker model which has been developed, in parallel, by clinical anthropologists. The importance is found in the fact that, like nurses, clinical anthropologists currently have very powerful professional interests vested in establishing positions for themselves as

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[27]Ibid., p. 355.
[28]Jezewski, MA. "Culture brokering as a model for advocacy," <u>Nursing and Health Care</u>, 14(2), 1993, pp. 78-85.
[29]Leininger, MM. "The transcultural nurse specialist: Imperative in today's world," <u>Nursing and Health Care</u>, 10(5), 1989, pp. 251-6.

culture brokers within the health care system. These professional interests first emerged not long after Kleinman's major works on health care provision across cultural divides were published in the late 1970's. They were, in large part, motivated by the need for the creation of employment positions for the growing number of clinical anthropologists. Hazel Weidman, a research oriented clinical anthropologist, has been a major proponent of the goal of professionalizing the culture broker role. In 1982, she described a program in which medical anthropologists served as professional culture brokers. This formalization and institutionalization of the culture broker role represented a major transition from the previous definition which anthropologists such as Eric Wolf had established for the culture broker, typically as an indigenous member of a cultural minority group. Weidman rationalized professionalizing the culture broker position by arguing that the definition created by Wolf and others resulted in an inherent asymmetry in the power relations between the culture broker (as subordinate) and the health care system.[30]

As will be discussed further below, the implementation of Weidman's model of clinical anthropologists as culture brokers has been problematic on a number of fronts. The sources of this difficulty include both internal and external factors. Internal factors include the difficulty which clinically oriented medical anthropologists have had in clarifying their role within medical institutions. External factors have primarily been economic. For example, inter-professional competition for culture brokering positions between clinical anthropologists, clinical nurses, social workers,[31] and others has been an almost inevitable offspring of the shortcomings in communication between professional groups. The difficulties that the resulting inter-professional redundancy

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[30]Weidman, HH. "Research strategies, structural alterations and clincally applied anthropology," in Clinically Applied Anthropology: Anthropologists in Health Science Settings, eds. Chrisman, NJ and Martzki, TW, Boston, D. Reidel Publishing Co., 1982, p. 213.
[31]Fandetti, DV and Goldmeier, J. "Social workers as culture mediators in health care settings," Health and Social Work, 13(3), 1988, pp. 171-9; Turner, FJ. "Social work practice theory: A trans-cultural resource for health care," Social Science and Medicine, 31(1), 1990, pp. 13-7.

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has produced are generally side-stepped in academic and health care related literature. However, Michael Phillips, a medical anthropologist, has recently acknowledged that "[ethnic counseling] anthropologists...are in direct competition with other professionals for shrinking resources; it is probable that disputes over professional territory will make their legitimization...difficult."[32]

If discourse on the culture broker model has evolved from a dialogue which focused primarily on theoretical models for negotiating between cultural systems to one in which health economics has become paramount, the reverse is essentially true for the other present model of the cultural knowledge specialist, the *lay health advisor/worker*. While the concept of the lay health advisor (variously referred to as the "community health worker," "indigenous health worker," "indigenous paraprofessional," etc.) shares its roots with the culture broker concept (in the early work of Eric Wolf) it represents an adoption of this concept which has followed a more pragmatic course. The concept of the lay health worker, an individual from a minority community with no prior professional training in health care provision, was developed primarily in the public health community within the United States in the late 1960s and 1970s. While the capacity of the lay health worker to serve as a "bridge between the middle class oriented professional and the client from the lower socioeconomic groups,"[33] was seen as an important benefit of this individual, the primary motivation for developing the concept of a non-health professional was in fact based on economic necessity. Lay health worker programs proliferated following passage of the Federal Migrant Health Act of 1962 and the Economic Opportunity Act of 1964, both of which recognized that both employment opportunity needs and major health care shortage problems in minority communities might be addressed by creation of these programs.[34] In contrast with the

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[32]Phillips, p. 34.
[33]Hoff, W. "Role of the community health aide in public health programs," Public Health Reports, 84(11), 1969, p. 1000.
[34]Flores-Ortiz, Y. "Indigenous paraprofessionals," in Reaching The Underserved, Mental Health Needs of Neglected Populations, ed. Snowden, Beverly Hills, Sage Publications, 1982,

scenario of inter-professional employment competition which has driven much of the present discourse on culture brokering models, the concept of the lay health worker was in fact created, in large part, to circumvent the problem of shortages in the number of public health nurses in the 1960s and 1970s.[35]

Because most lay health programs were funded by federal dollars, which became increasingly scarce in the 1980s, the rationale for developing such programs tended to shift with the political climate in this period, which increasingly favored cultural etiologies for health access inequities over socioeconomic causes. More recently, such programs have emphasized the unique attributes which lay health workers provide in serving as cultural "bridges" between local communities and the health care system, as was outlined in Wolf's early definition of the culture broker. Perhaps it is for this reason that the terms culture broker and lay health worker have increasingly been used interchangeably, despite the fact that they have very different theoretical sources and practical applications.

From Theory to Application of Patient-Practitioner Level Models:

A major criticism of models which propose modifying the patient-practitioner level interaction to become more culturally competent is that the transition from theory to implementation has, in general, been problematic. Operationalizing the fairly abstract models proposed by Kleinman, Leininger, and others has been far less than straightforward, particularly given the immense variation in clinical environments which are possible. For example, the nuances of making practitioners more culturally competent in an emergency room setting versus a psychiatric in-patient facility versus a skilled-nursing facility have proven very difficult to articulate.

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p. 259; Meister, JS, et al. "Using lay health workers: Case study of a community-based prenatal intervention," Journal of Community Health, 17(1), 1992, p. 38.
[35]Wingrert, WA, et al. "Effectiveness and efficiency of indigenous health aides in a pediatric outpatient department," American Journal of Public Health, 65(8), 1975, p. 850.

In addition, there is an inevitable variation in the specific interface between culture and health beliefs and behaviors, and its relative importance in altering health accessibility issues, from one cultural minority community to another. Moreover, it is often difficult for those designing interventions to isolate which aspects of inadequate health access or utilization in a particular group are related to cultural factors and which are attributable to non-cultural factors, such as socioeconomic status, education level, etc. Because cultural and non-cultural factors often influence and inform one another, it can be argued (as many critical anthropologists have, in effect, argued) that interventional approaches not attempt to isolate them from one another. However, approaches which fail to do so run the danger of confusing non-cultural issues with those directly related to culture. Take, for example, a recent intervention undertaken to increase levels of diabetes awareness among Native American populations in the Pacific Northwest. The specific intervention was actually directed at the problem of low literacy in these communities, consisting of distributing diabetes education booklets at a lower grade-reading level than was typical in other communities. However, the authors concluded that, in doing so, they had succeeded in making the educational materials more "culturally sensitive."[36] It is important to note that this example illustrates a fairly extreme case; in others, distinguishing cultural from non-cultural issues is more difficult.

Putting issues of specific content aside for the moment, a review of recent health related literature using terminology related to cultural competency (e.g. culturally appropriate, culturally sensitive, etc.) reveals a number of general trends. In order to better understand recent efforts to operationalize the patient-practitioner models outlined above, it is useful to view this work as essentially forming a pyramid of research. At the base of this pyramid is a relatively vast body of descriptive

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[36]Hosey, GM and Freeman, WL; Stracqualursi, F; and Gohdes, D. "Designing and evaluating diabetes education material for American Indians," Diabetes Educator, 16 (5),1990, p. 407.

ethnographic research which has been produced primarily by medical anthropologists--although a growing number of such works have emerged from other disciplines, such as clinical psychiatry and transcultural nursing. These ethnographies range from very broad descriptions which attempt to typify the health relevant aspects of culture for large ethnic groups to those which focus very exclusively upon a single aspect of health for a specific community or subcultural group. At the next level of this pyramid are numerous efforts to review this descriptive work, and to form clinically applicable strategies for integrating this knowledge. At the top of the pyramid is a fairly small set of work which has actually studied interventions to increase cultural competency at the patient-practitioner level. While the implementation of programs attempting to emulate the models described above has likely been widespread, there have unfortunately been relatively few published works documenting specific clinically based examples of their implementation, and an even smaller number which have evaluated these interventions with valid qualitative or quantitative techniques. It is not surprising then, to find that examples of such interventions create a patchwork of pieces which cannot always be worked into a coherent whole.

A comprehensive review of the descriptive ethnographies which form the foundation of interventions at the patient-practitioner level is far beyond the scope of this paper. Indeed, there are entire journals which are devoted to this work. Nonetheless, a number of trends are worth noting. First, there has been a broad spectrum of such work with respect to the specificity of content. On one end of this spectrum are those efforts which attempt to provide very broad, generalized descriptions of the health relevant cultural practices and beliefs of entire ethnic groups. Because of the presumed facility of accessibility afforded by such an approach, these broad descriptions have become popular and, in a few cases, have actually been

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incorporated into textbooks.[37] However, an obvious shortcoming of such approaches is that they tend to equate ethnicity with culture, and ignore sub-ethnic variations in culture. On the other end of the spectrum are those efforts which have focused very specifically upon one particular cultural minority community, and even on one particular aspect of health within that community. To cite a small sample of such examples, researchers have recently studied such specific phenomena as: the interface between culture and chronic pain among Puerto Rican immigrants to New England,[38] cultural influences on domestic violence among urban Cambodian refugees,[39] the significance of culturally based perceptions of diarrhea among Haitian mothers,[40] and the impact of cultural factors on the decision to have a family member autopsied among Mexican-Americans versus Anglo-Americans.[41] While works such as these are critical in drawing attention to aspects of the health-culture interface in certain communities which would otherwise be neglected, an obvious limitation is that they tend to provide data which is difficult to integrate into interventional programs.

A second generalization which can be made is that there has been a tendency of work within particular cultural minority communities to be "territorialized," whether actively or inadvertently, by researchers from different disciplines. For example the work of medical anthropologists has, until very recently, overwhelmingly focused upon groups which have either immigrated to this country recently or have been more culturally isolated from Western culture. This is not surprising given that 1) historically,

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[37]Henderson, G and Primeaux, M. Transcultural Health Care, Menlo Park, CA, Addison-Wesley Publishing Co, 1981; Spector, RE. Cultural Diversity in Health and Illness (3rd ed.), Norwalk, CT, Appleton and Lange, 1991; Harwood, A. Ethnicity and Medical Care, Cambridge, MA, Harvard University Press, 1981.

[38]Bates, MS and Rankin-Hill, L. "Control, culture and chronic pain," Social Science and Medicine, 39(5), 1994, pp. 629-45.

[39]Frye, BA. "Cultural themes in health-care decision making among Cambodian refugee women," Journal of Community Health Nursing, 8(1), 1991, pp. 33-44.

[40]Kirkpatrick, SM and Cobb, AK. "Health beliefs related to diarrhea in Haitian children: Building transcultural nursing knowledge," Journal of Transcultural Nursing, 1(2), 1990, pp. 2-12.

[41]Perkins, HS. "Cultural differences and ethical issues in the problem of autopsy requests," Texas Medicine, 87(5), 1991, pp. 72-7.

much of medical anthropology is based upon studying health beliefs and behaviors in the Third World (in the arena commonly referred to as "ethnomedicine") and 2) researchers have no doubt found such work more rewarding because of the fact that such groups tend to express health beliefs which are less consistent with the culture of the Western medical system (and, as a result, cultural barriers to medical care are more obvious among these groups). For example, research has disproportionately studied the health relevant aspects of culture among recent immigrants from Asia (particularly those from Southeast Asian countries) and immigrant groups from Latin America. In contrast, work from the public health community has tended to focus upon health relevant cultural factors among groups which have had a longer history of being underserved by the health care system, such as inner-city African-American and Latino populations, rural migrant populations, and Native American populations. While these trends are merely intended as generalizations, and it is acknowledged that recent research has been moving in the direction of blurring these distinctions, their existence is noteworthy because of the divergence of approaches which different disciplines have taken in studying the health-culture interface. For example, ethnographic data produced by medical anthropologists frequently emphasizes health belief systems within cultural groups as discrete entities (for example, resulting in formulations of so called "culture-bound" syndromes), whereas work from the public health community has tended to view culture as a broader, socioeconomically influenced concept. As a result, it is often difficult to transfer results from one context to another.

As noted above, the vast bulk of ethnographic work which has examined the interaction of culture and health among various groups has focused on culture as an ethnicity-defined and ethnicity-bound concept. In other words, ethnicity has almost invariably been considered to be nearly synonymous with culture--a fact which is deeply rooted in the very foundations of anthropology. However, there has recently been a noticeable trend in efforts to discuss culture as a concept which can transcend ethnicity.

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For example, some research has attempted to promote a modification of the definition of culture to discuss gay, lesbian, and bisexual groups as cultural or sub-cultural groups, which share certain beliefs, behaviors, and identities which are relevant to health.[42] In a similar manner, guidelines for examining deafness as a culture defining concept have been discussed.[43] Others have discussed the utility of examining violence as an independent cultural phenomenon, which is transmitted vertically within socially and economically oppressed urban populations, and which has implications for the treatment of certain health related problems.[44]

Aside from the theoretical potential to utilize culture as a normalizing denominator in such cases, there are obvious political benefits in doing so. Indeed, the current attentiveness to discourse related to cultural competency offers the potential to focus considerable resources upon otherwise neglected areas. Nonetheless, the notion that a primarily social identity such as homosexuality or deafness might be equated to ethnicity--a socially and biologically inherited identity which is not only the product of long-standing, complex communities and societies, but in many cases the source of generations of oppression--is a controversial one. Even so, while one might expect a considerable debate to evolve in this area in the near future, there does not yet appear to be prominent objection being voiced against the use of culture as a vehicle for mainstreaming issues which have largely been marginalized by the health care system. One might speculate that current political and social constraints within academia make the vocalization of positions scrutinizing this trend problematic.

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[42]Eliason, MJ. "Cultural diversity in nursing care: The lesbian, gay, or bisexual client," Journal of Transcultural Nursing, 5(1), 1993, pp. 14-20.

[43]Arnos, KS, Israel, J, and Cunningham, M. "Genetic counseling of the deaf. Medical and cultural considerations," Annals of the New York Academy of Sciences, 630, 1991, pp. 212-22; Arnos, KS, et al. "Innovative approach to genetic counseling services for the deaf population," American Journal of Medical Genetics, 44(3), 1992, pp. 345-51.

[44]Wallace, BC. "Cross-cultural counseling with the chemically dependent: Preparing for service delivery within a culture of violence," Journal of Psychoactive Drugs, 25(1), 1993, pp. 9-20.

While there has been an abundant proliferation of descriptive work forming the foundation upon which to develop culturally competent interventions at the patient-practitioner level, the actual development of interventions based on the models of Leininger, Kleinman, and others has emerged more slowly. There have been relatively few areas in the health care system in which such interventions have in fact been implemented in a controlled manner which can readily be evaluated. The reasons for this difficulty are numerous and include: 1) the fact that interventions are often implemented at multiple levels (i.e. practitioner, community-based organization, and policy) which address cultural as well as non-cultural variables--making it impossible to ascertain whether practitioners' awareness of cultural influences were in fact modified in a tangible manner; 2) the fact that resources in the literature for developing practitioner awareness of cultural issues are often fragmented and inconsistent, making it difficult to develop comprehensive interventions; and 3) the fact that interactions between patients and practitioners are inherently idiosyncratic, dependent on the specific context of the clinical encounter. As one observer has noted, "Effectively implementing this sort of program can be difficult, since cultural issues are often subtle, invisible, or deemed less important than acute symptomatology."[45]

This is not to say that there has been a lack of interest in this area. Clinical practitioners and researchers have repeatedly sounded the need for developing and evaluating specific patient-practitioner level culturally appropriate interventions, particularly when they have documented a grass roots level need. The literature abounds with proposals for implementing patient-practitioner level models of culturally competent care within various health care contexts. For example, these proposals have included novel methodologies for implementing focus groups in waiting rooms, utilizing

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[45]Foster, SW. "The pragmatics of culture: The rhetoric of difference in psychiatric nursing," Archives of Psychiatric Nursing, 4(5), 1990, p. 294.

participant-observer techniques in the physician's office,[46] and assessing families as cultural units.[47] However, a review of the literature finds that there are very few documented examples of such interventions having been implemented in actual clinical settings. There have also been numerous proposals for improving patient-practitioner level cultural competence for very specific health care contexts. For example, recommendations have been set forth for such varied clinical settings as providing culturally competent care for terminally ill patients in various cultural contexts,[48] for offering culturally sensitive breast cancer screening,[49] for promoting breast feeding in a culturally sensitive manner,[50] and offering diet counseling in a manner which fosters awareness of cultural issues.[51] While such proposals tend to offer highly specific approaches to offering services in manner consistent with the models discussed above, there is little evidence of the extent to which they have penetrated into the health care system. Furthermore, as will be discussed further below, issues of efficacy and validity within such approaches have not, in general, been resolved.

Two areas in which interventions at the patient-practitioner level have received considerable attention are: 1) practitioner education programs and 2) programs which

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[46]Mull, JD. "Cross-cultural communication in the physician's office," Western Journal of Medicine, 159(5), 1993, pp. 609-13.

[47]Morris, TM. "Culturally sensitive family assessment: An evaluation of the family assessment device used with Hawaiian-American and Japanese-American families," Family Process, 29(1), 1990, pp. 105-16; Cousins, JH, et al. "Family versus individually oriented intervention for weight loss in Mexican American women," Public Health Reports, 107(5), 1992, pp. 549-55.

[48]Pickett, M. "Cultural awareness in the context of terminal illness," Cancer Nursing, 16(2), 1993, pp. 102-6; Beyene, Y. "Medical disclosure and refugees. Telling bad news to Ethiopian patients," Western Journal of Medicine, 157(3), 1992, pp. 328-32; Tong, KL and Spicer, BJ. "The Chinese palliative patient and family in North America: A cultural perspective," Journal of Palliative Care, 10(1), 1994, pp. 26-8.

[49]Brown, LW and Williams, RD. "Culturally sensitive breast cancer screening programs for older Black women," The Nurse Practitioner, 19(3), 1994, pp. 21, 25-6, 31; Saint-Germain, MA and Longman, AJ. "Breast cancer screening among older Hispanic women: Knowledge, attitudes, and practices," Health Education Quarterly, 20(4), 1993, pp. 539-53; Yancey, AK and Walden, L. "Stimulating cancer screening among Latinas and African-American women. A community case study," Journal of Cancer Education, 9(1), 1994, pp. 46-52.

[50]Abramson, R. "Cultural sensitivity in the promotion of breastfeeding," NAACOGS Clinical Issues in Perinatal Women's Health Nursing, 3(4), 1992, pp. 717-22.

[51]Kittler, PG and Sucher, KP. "Diet counseling in a multicultural society," Diabetes Educator, 16(2), 1990, pp. 127-34.

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utilize culture brokers or lay health workers according to the models discussed above. In the past fifteen years, a number of approaches to educating health care practitioners to become more culturally sensitive have been proposed. A handful of these have been implemented, although in general their application has been very limited in scope. The models for educating health care practitioners have, for the most part, been extensions of the broader models for providing culturally sensitive care discussed above. For example, Judith Lynam has described a conceptual model for educating nursing students to become more culturally competent which is almost entirely derived from the theories of Leininger and Kleinman.[52] Similarly, Elois Berlin and William Fowkes have presented a LEARN (listen, explain, acknowledge, recommend, negotiate) model for cross-cultural training of physicians which is consistent with the general approach recommended by Kleinman.[53] Jeffrey Borkan and Jon Neher have proposed a "developmental model" for cultural sensitivity training, which utilizes an "ethnosensitivity" spectrum similar to that of Cross, et al. (discussed above), in which approaches are offered for training practitioners at each level of ethnosensitivity (fear, denial, superiority, minimization, relativism, empathy, and integration).[54] While not specifically founded on the biopsychosocial models for culturally competent care, Richard Brislin and Tomoko Yoshida recently published two textbooks to guide social service workers, not limited to health care professionals, in developing inter-cultural communication training programs. Their work provides recommendations for factors critical in developing such programs, offering a broad range of perspectives, from approaches to needs assessment to

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[52]Lynam, MJ. "Towards the goal of providing culturally sensitive care: Principles upon which to build nursing curricula," Journal of Advanced Nursing, 17, 1992, pp.149-57.
[53]Berlin, EA and Fowkes, WC. "A teaching framework for cross-cultural health care," Western Journal of Medicine, 139(6), 1983, pp. 934-8.
[54]Borkan, JM and Neher, JO. "A developmental model of ethnosensitivity in family practice training," Family Medicine, 23(3), 1991, pp. 212-7.

administration of such programs to developing the specific content of curricula in such programs.[55]

The depth and specificity of educational interventions for health professionals has varied considerably. Some approaches to educating health professionals to become more culturally competent have attempted to isolate this training into a discrete intervention, either as an ongoing classroom course or as an intensive workshop. Some of these programs have had largely predetermined curricula, whereas others have focused more on idiosyncratic small group dynamics as a source for educating health workers. For example, researchers and educators at Rush Medical College developed an educational program for medical students which included a 40 hour course in cultural competency training which emphasized didactic learning.[56] This course focused specifically upon aspects of health and culture within Hispanic communities in both the United States and Mexico and was correlated with a Spanish language course. An intervention at the University of Southern California, which utilized videotaped materials and panel discussions in addition to lectures, attempted to discuss cultural issues affecting health care among a broader number of groups (e.g. the homeless, African-Americans, Hispanics, Asian-Americans, homosexual men and women, and Native Americans) by developing discrete "modules" for each group.[57] In contrast to these largely pre-programmed educational approaches, Elaine Pinderhughes has described an experiential group process approach to "teaching empathy," in which clinical health workers were asked to confront issues of power inequity as they related to cultural differences between providers and patients. The primary educational

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[55]Brislin, RW and Yoshida, T. Intercultural Communication Training: An Introduction, Thousand Oaks, CA, Sage Publications, 1994; Brislin, RW and Yoshida, T. Improving Intercultural Interactions: Modules for Cross-Cultural Training Programs, Thousand Oaks, CA, Sage Publications, 1994.
[56]Nora, LM, et al. "Improving cross-cultural skills of medical students through medical school-community partnerships," Western Journal of Medicine, 161(2), 1994, pp. 144-7.
[57]Stumpf, SH and Bass, K. "Cross cultural communication to help physician assistants provide unbiased health care," Public Health Reports, 107(1), 1992, pp. 113-5.

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resources used in this approach were the cultural identities and experiences of individual clinicians who participated. Training interventions offered as small components of larger medical curricula are often greatly limited by administrative factors, such as funding resources and scheduling priorities. For example, a second educational program implemented at the University of Southern California, which was based on the LEARN model described above, attempted to integrate an intensive four hour workshop (using videotaped materials, discussions, and role-playing exercises) into a much larger introduction to clinical medicine course for medical students.[58]

While approaches such as those just discussed have tended to isolate cultural competency training from other aspects of health provision (possibly because they have largely been oriented towards students training to become health providers, rather than towards health professionals per se), other interventions have attempted to integrate such training into the daily clinical activities of practitioners. A common means for attempting to accomplish this integration is through programs in which clinicians are required to routinely work exclusively within a particular cultural minority community. While this method of cultural sensitivity training, labeled "cultural immersion" by Jeffrey Borkan and others,[59] is no doubt the most comprehensive means for developing awareness and understanding of the health-culture interface for a particular cultural minority group, the implementation of specific programs using this method has been relatively uncommon. Examples of programs which have taken this approach include the project at Rush Medical College mentioned above. In addition to developing the largely theory based course in cultural sensitivity training, this program included clinical experiences for students to work with cultural minority populations through a partnership with a community health organization serving Chicago's Hispanic populations. Educators in the University of California at San Diego's Family Medicine

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[58]Mao, C, et al. "A workshop on ethnic and cultural awareness for second-year students," Journal of Medical Education, 63, 1988, pp. 624-8.
[59]Borkan and Neher, p. 212.

Residency Program developed a highly integrated approach, in which second-year residents, in addition to having to attend didactic cross-cultural training, were required to spend a half-day per week for an entire year at a community clinic on the Mexican-American border.[60] While similar academic programs have no doubt been implemented in other communities, it is difficult to assess their prevalence as there has been little published work documenting the experiences of such "cultural immersion" programs for training health care providers.

In addition to the educational programs just discussed, interventions utilizing culture brokers or lay health advisors have also received a significant amount of attention in the health care literature. The use of non-professional health advisors from within cultural minority communities has been relatively widespread in numerous "culturally sensitive" community-based programs, and will be discussed first. Nonetheless, while use of lay health workers has been fairly common, as Paul Giblin has pointed out, they have periodically "gone in and out of fashion," since the role was first introduced in the 1960s.[61] Furthermore, the exact nature in which such lay health advisors have been utilized has varied considerably.

Traditionally, lay health workers have been used primarily as community outreach workers. In this capacity, they are essentially non-professional public health workers, serving either to increase participation in a specific preventive health program or to provide social support for the program in an adjunct capacity. While their utilization internationally has been very well described, with the Chinese "barefoot doctors" which emerged in the midst of the Cultural Revolution being perhaps the most prototypical such example,[62] the following discussion will be limited to domestic

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[60]Kristal, L, et al. "Cross-cultural family medicine residency training," Journal of Family Practice, 17(4), 1983, pp. 683-7.
[61]Giblin, PT. "Effective utilization and evaluation of indigenous health care workers," Public Health Reports, 104(4), 1989, p. 361.
[62]Stark, R. "Lay workers in primary health care: Victims in the process of social transformation," Social Science and Medicine, 20(3), 1985, pp. 269-75.

developments. In the United States, such efforts have generally been directed at public health problems for which the targeted minority communities have suffered from an increased prevalence. For example, lay health workers have recently been used to increase community participation in smoking cessation programs for inner city African-American populations, for whom the incidence of smoking associated morbidity and mortality (e.g. cancer, heart disease, etc.) have consistently been demonstrated to be much higher.[63] They have similarly been used to increase breast and cervical cancer screening in Native American and Mexican-American populations, for whom the average survival following a diagnosis with such cancers has been notably foreshortened relative to non-Hispanic Whites.[64] It is important to note that in such interventions, the use of lay health workers has usually been one approach among multiple public health education and outreach strategies utilized simultaneously. Furthermore, the use of the lay health worker is almost always subordinate to other functions in these programs. In addition, the use of lay health workers in this type of public health oriented context has not been limited to "culturally sensitive" interventions or interventions directed at minority populations. Because of their cost-effectiveness, lay health workers have been an important component of numerous generalized public health screening and education programs.[65]

Lay health workers have also been used in clinical contexts, performing roles as both medical (or quasi-medical) personnel and as community representatives. For example, one of the earlier examples of the utilization of lay health workers involved extensive training of several members of an underserved community, with the goal that they perform many of the tasks of public health nurses in a pediatric clinic (e.g. screening

[63]Lacey, L, et al. "Use of lay health educators for smoking cessation in a hard-to-reach urban community," Journal of Community Health, 16(5), 1991, pp. 269-82.
[64]Brownstein, JN, et al. "Breast and cervical cancer screening in minority populations: A model for using lay health educators," Journal of Cancer Education, 7(4), 1992, pp. 321-6.
[65]Linnan, L, et al. "Training health professionals and lay volunteers to deliver cholesterol screening and education programs," Public Health Reports, 105(6), 1990, pp. 589-98.

patients, performing survey interviews of community members, etc.). In this particular case, lay health workers were employed not only to "improve communication between highly educated White middle class professionals and a low socioeconomic minority group...offering a cultural and economic viewpoint [from this community]," but also to "save professional time, thus extending health manpower."[66] Of course, because of the extensive training involved in providing lay health workers with adequate clinical acumen in such a program, the description of these workers as "lay" individuals requires a certain amount of protraction of basic definitions. Indeed, the medicalization of lay health workers is not without conceptual conflicts regarding professional hegemony issues. The experience of a recent prenatal intervention for migrant and seasonal farm workers in the Southwest, utilizing lay health workers as well as clinical nurses and professionally trained culture brokers, found that professional health worker versus lay health worker conflicts were frequently a significant problem.[67]

In other cases, the role of lay health workers has been more analogous to that of professional culture brokers, in that they have been used as cultural mediators in clinical encounters between patients and practitioners. In a few cases, this role has even extended into the utilization of a culturally indigenous health system as the central interventional strategy. One of the most striking examples of such a use of lay health workers is that of a crisis intervention program which was first implemented on the Papago Indian Reservation in Arizona in the early 1970s. This program, which provided services for various acute psychiatric problems, frequently utilized traditional medicine men and women as consultants.[68] Because of the program's highly unique nature, with clinical interventions being based largely in principles of mental disease grounded in the

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[66]Wingrert, WA, et al. "Effectiveness and efficiency of indigenous health aides in a pediatric outpatient department," American Journal of Public Health, 65(8), 1975, pp. 849-57.
[67]Meister, et al.
[68]Kahn, MW, et al. "An indigenous community mental health service on the Tohono O'odham (Papago) Indian Reservation: Seventeen years later," American Journal of Community Psychology, 16(3), 1988, pp. 369-79.

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culture of the community served, this case provides an example in which it would be more appropriate to refer to the providers as "indigenous" health workers rather than as "lay" health workers.

Shifting now to a discussion of the utilization of professionally trained culture brokers, one finds that there are considerably fewer written entries in the medical or health care related literature describing the use of clinical anthropologists as culture brokers in mediating health provision interactions. This is somewhat surprising, given that the great bulk of the theory of culturally competent care at the individual practitioner level revolves around the goal of attaining the degree of cultural relevance which a culture broker is, in principle, to control. In part, this phenomenon may be attributed to the fact that the development of culture brokering interventions has been most abundant in the domains of international health and ethnomedical anthropological research, and not in clinical contexts within the United States. While it is likely that culture brokers are utilized fairly widely throughout the American medical system, particularly in health care interactions with populations who have immigrated more recently, it is impossible to gauge the degree to which their use has penetrated into various clinical settings. This is not to say that there has not been interest in anthropological concepts of culture brokering emerging from other medical professions. For example, a number of proposals for utilizing these concepts have been presented by family practice physicians in recent years.[69] There has also been interest in developing culture brokering approaches specific to mental health services provision.[70]

While there has been a peculiar absence of publications describing specific applications of culture brokering models by clinical anthropologists, the field of

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[69]Galazka, SS and Eckert, JK. "Clinically applied anthropology: Concepts for the family physician," Journal of Family Practice, 22(2), 1986, pp. 159-65; Like and Steiner; Mull.
[70]Schwab, B, Drake, RE, and Burghardt, EM. "Health care of the chronically mentally ill: The culture broker model," Community Mental Health Journal, 24(3), 1988, pp. 174-84; Richards, W. "A community systems approach to research strategies," American Indian and Alaska Native Mental Health Research, 2(3), 1989, pp. 51-7.

transcultural nursing, has, in contrast, disseminated a growing number of examples of culture brokers being utilized in various clinical contexts. Such applications of culture brokering concepts have developed largely within the last five years, coinciding with the consolidation of transcultural nursing into a discrete nursing specialty. Transcultural nurses have been utilized as culture brokers in programs ranging from prenatal care of recent Southeast Asian immigrants to the mediation of do-not-resuscitate decisions in critical care units.[71] They have also been utilized in contexts where lay health worker strategies have been prominent, as in the provision of health services to migrant farm workers.[72] While transcultural nursing has been particularly enthusiastic in promoting culture brokering in a range of clinical situations, it is important to note that specific roles and even basic definitions of culture brokering have varied from case to case. In some instances, culture brokering has been a task reserved for nurses trained specifically in the provision of transcultural services to a particular group. In others, the term is utilized to reflect a more generic role, which is presented as one among many functions performed by nurses. Problems encountered in the evaluation of culture brokering interventions will be discussed further below.

Evaluation of Interventions at the Patient-Practitioner Level:

Before briefly summarizing and commenting on the findings of evaluations which have been performed in this area, a few caveats are warranted. To begin with, the evaluation of individual practitioner level interventions identified as culturally sensitive, appropriate, competent, etc. has been highly variable with respect to both methodology and depth of research. For example, many interventions have not included a formal evaluation methodology in their design, and have not therefore been evaluated at all. Of

[71]Mattson, S and Lew, L. "Culturally sensitive prenatal care for Southeast Asians," Journal of Obstetric, Gynecologic and Neonatal Nursing, 21(1), 1992, pp. 48-54; Jezewski, MA. "Do-not-resuscitate status: Conflict and culture brokering in critical care units," Heart and Lung, 23(6), 1994, pp. 458-65.
[72]Jezewski, MA. "Culture brokering in migrant farmworker health care," Western Journal of Nursing Research, 12(4), 1990, pp. 497-513.

those which have been assessed through a structured process, the specific types of variables evaluated differ considerably from cases to case. For example, some interventions have been analyzed with respect to the process of developing the intervention. Others, such as those with highly specific goals, have primarily been evaluated with respect to outcome. While few would disagree with the position that both process oriented and outcome oriented evaluations are critically necessary if more effective interventions are to evolve in the future, there are at the same time valid arguments to be made to the effect that program evaluation in this area is often haphazard. Another important consideration to take into account in discussing program evaluation in this area is that, in most cases, multiple interventions are implemented simultaneously. Although this circumstance is an unavoidable product of the fact that, in their essence, most programs implemented under the rubric of culturally competent care are pragmatic in nature (and are not generally intended to be finely controlled experiments), it can result in significant problems of interference and overlap between interventions. Having alluded to some of the general factors which make the evaluation of individual practitioner level interventions difficult, we can now proceed with an examination of some of the specific approaches which have been developed.

Because many of the interventions utilized in this area are intended to make practitioners more culturally competent (as in the case of the various cultural sensitivity education programs which have been implemented), it might seem that a logical first step in evaluating these programs would be the development of an instrument for assessing or measuring an individual health care provider's capacity to provide care in a culturally competent manner. In practice, there have been very few efforts to accomplish this end. This fact is perhaps not surprising, given the daunting nature of the task of having to identify the multitude of factors which might be considered as contributing to cultural competency. If one also takes into consideration the significant variation and ambiguity in definitions of cultural competency from one source to another, the endeavor

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becomes that much more problematic. To date, the two most ambitious efforts to develop such an instrument have emerged from the counseling psychology community. In 1991, Teresa LaFromboise, et al. presented the Cross-Cultural Counseling Inventory (CCCI), which was later revised (to the CCCI-R). This 22 item self-report instrument was based upon three dimensions of cross-cultural counseling competency developed by the American Psychological Association (APA): 1) beliefs and attitudes, 2) knowledges, and 3) skills. Studies found it to have adequate interrater reliability and validity.[73] In 1994, a group at the University of Nebraska presented the Multicultural Counseling Inventory (MCI), another self-report instrument based on the APA dimensions. The MCI was validated by factor analysis following extensive administration to 604 psychology students, psychologists, and counselors in Nebraska, and 320 university counselors from a national sample.[74]

While both the CCCI and the MCI represent laudable research efforts, their utilization in health care research has been extremely limited. Even within the field of counseling psychology, these instruments have been used in but a handful of instances. Only one case could be found in which the MCI was administered in a cross-sectional manner to assess the prevalence and degree of cultural competency among clinical practitioners in a realm outside of mental health (in this case, nursing students in general training were the study group).[75] In fact, the use of any type of measure, whether self-administered or through third-party rating, to gauge an individual health care provider's cultural sensitivity/competency capacity in any research in this area has been rare.

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[73]LaFromboise, TD, Coleman, HL, and Hernandez, A. "Development and factor structure of the Cross-Cultural Counseling Inventory--Revised," Professional Psychology: Research & Practice, 22(5), 1991, pp. 380-8.

[74]Sodowsky, GR, et al. "Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies," Journal of Counseling Psychology, 41(2), 1994, pp. 137-48.

[75]Pope-Davis, DB, Eliason, MJ, and Ottavi, TM. "Are nursing students multiculturally competent? An exploratory investigation," Journal of Nursing Education, 33(1), 1994, pp. 31-3. Incidentally, this study was not performed as part of an assessment of an educational program, but did conclude that nursing students with some general work experience had significantly more self-perceived multicultural skill than those without work experience.

Furthermore, when such efforts are made, definitions and criteria are typically idiosyncratic. For example, one of the only published efforts to rate health professionals in a general community practice setting along a spectrum of cultural competency used a somewhat capricious classification system including the following categories: "culturally unaware," "culturally intolerant," and "culturally sensitive."[76]

Given that no consensus presently exists regarding a standard measure of cultural competency at the individual provider level, serious problems arise when attempting to assess the effectiveness of educational programs and other efforts designed to enhance the cultural sensitivity of practitioners. Among those educational interventions which have been reported, program evaluations--when they have been performed at all--have frequently been based either on proxy measurements of cultural competency or upon success in achieving internal program goals. For example, the only evaluation mechanism included in the four-hour workshop intervention for USC medical students (discussed in the previous section) was an objective questionnaire assessing students' impressions of the course and pre- and post-intervention changes in students' abilities to answer nine "sociocultural attitude" questions "correctly."[77] The Rush Medical College cross-cultural training program discussed above provides an example of a somewhat more rigorous evaluation process. The example is notable because it utilized an experimental as well as a control group. Students in both groups were assessed for pre- and post-test proficiency in Spanish-English translation and "knowledge of Hispanic health and cultural issues" through objective format tests. The results demonstrated significant improvements in the experimental group relative to the control group.[78]

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[76]Blenner, JL. "Health care providers' treatment approaches to culturally diverse infertile clients," Journal of Transcultural Nursing, 2(2), 1991, pp. 24-31.
[77]Mao, et al.
[78]Nora, et al., p. 146.

Besides the problem of using relatively arbitrary criteria for measuring program success, the question also arises in such examples as to whether improvements in responses to written tests or questionnaires translate into improved clinical effectiveness. Hence, an alternative type of outcome evaluation utilized in educational interventions, has been an assessment of changes in clinical functioning among participants. While these efforts are considerably more labor intensive to conduct, a number of examples of such approaches do exist. Overall, the few existing results of such studies are encouraging. For example, a cultural sensitivity training workshop for African-American and White counseling psychologists measured its effects through client ratings of counselors. This small study demonstrated that clients found trained counselors to be more expert, trustworthy, and empathic than those who had not received training, and perhaps more significantly, that these effects were true exclusive of the ethnicity of counselors.[79] Perhaps the best example of an intensive evaluation of an educational intervention is found with the Cross-Cultural Training Institute for Mental Health Professionals (CCTI), the largest cultural competency training program ever implemented (it is further discussed in the next chapter). The CCTI provided training over three years for a national cross-section of 174 mental health professionals (primarily clinicians, with representation among administrators, researchers, and educators as well). Evaluation of the project was multi-faceted, consisting of objective and subjective measures of both: 1) short-term changes in clinical effectiveness of participants (e.g. through questionnaires and videotaped patient-participant interactions) and 2) long-term changes in the utilization, by minority populations, of services offered by agencies participating in the program. On both fronts, significant improvements were observed. In particular, the study found that, following participation in the CCTI, both individuals and agencies showed: 1) increases in their

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[79]Wade, P and Bernstein, BL. "Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition," Journal of Counseling Psychology, 38(1), 1991, pp. 9-15.

minority caseloads and 2) decreases in dropout rates among minority clients. The study was also one of the only cultural competency interventions of any kind which assessed cost-effectiveness, demonstrating a net savings of three-quarters of a million dollars for participating agencies.[80]

While the above examples indicate that there is growing evidence that cultural sensitivity training programs are effective on a number of fronts, a broader question to be asked in evaluating their potential long-term effectiveness is that of how widespread the use of such programs is within the health care system. Unfortunately, in this area, there is little existing data. Only two such studies have been performed to date. The first was a 1984 report by Madeline Leininger, which found that 18% of undergraduate and 13% of graduate nursing programs included course content addressing multicultural issues.[81] The second was a survey of all 126 accredited American medical schools, performed in 1992, to assess the prevalence of cultural sensitivity training courses. The study found that only 13 of the 98 responding schools offered any such courses, and that these courses were optional at all but one school. Of additional interest, the study found that between schools with such courses and without them, there were no significant differences in the perceptions of recent graduates regarding their capacity to provide culturally sensitive services.[82] An additional factor to consider in interpreting these findings is that the content of cultural sensitivity training varies considerably from one site to another, and that these studies did not measure such variation. Clearly, this is an area in need of further examination. In particular, there is no existing data examining the availability of cultural sensitivity training programs or courses in the health care system at large, for clinicians who have already received their professional training.

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[80]Lefley, H. "Cross-cultural training for mental health professionals: Effects on delivery of service," Hospital and Community Psychiatry, 35(12), 1984, pp. 1227-9.
[81]Leininger, MM. "Transcultural nursing: An overview," Nursing Outlook, 32), 1984, pp. 72-3.
[82]Lum, CK and Korenman, SG. "Cultural-sensitivity training in U.S. medical schools," Academic Medicine, 69(3), 1994, pp. 239-41.

If existing data on the prevalence of cultural sensitivity training programs in the health care system is spotty, data on the prevalence of lay health worker and culture broker utilization is essentially non-existent. While there has been considerable discussion of the theoretical merits of utilizing these mediators of cross-cultural health care transactions, there has unfortunately been little discussion of their availability in the health care system as a whole.

To date, the only attempt to comprehensively assess the spectrum of lay health worker utilization patterns is that of Paul Giblin. In 1989, Giblin published a review of the various public health and clinical contexts in which lay health workers (referred to as indigenous health care workers or IHCWs in the report) had been used in the preceding quarter-century. Giblin examined each of 19 examples along three variables: 1) the specific tasks of each program, 2) the rationale for each program (e.g. cultural, economic, etc.), and 3) the method of evaluation utilized (if any). The study revealed that the most common uses of IHCWs were in the provision of pre- and post-natal outreach and in enlisting participation in health screening and immunization programs. The most common rationale for utilizing IHCWs in the programs reviewed was to provide language and cultural interpretation services, although in a significant number of cases cost was the primary motivator for their use. Giblin found that the most commonly used evaluation approach was the measurement of some type of quantifiable outcome variable, such as a change in the utilization of health services or, in some cases, a change in a relevant health index. Overall, the findings of these projects supported the notion that IHCWs significantly increased the health of clients and that their use was very cost-effective. Furthermore, in cases in which IHCWs medical effectiveness was compared with that of trained health professionals, they were found to be as effective in performing many basic public health worker functions. Giblin's strongest critique of the evaluation of lay health worker interventions was the fact that almost all of the programs failed to include a mechanism for assessing: 1) the value of IHCWs' cultural

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skills (or as he termed it, their "indigenousness") in contributing to program success and 2) changes in IHCWs skills or knowledge of health issues. In his conclusion, Giblin proposed that future evaluations of such programs incorporate an *action research* methodology, in which empirical research and continuous progress monitoring would be incorporated into the evaluation strategy. He also presented a schema for selecting and training lay health workers.[83]

Giblin's study also pointed to a number of other significant issues relating to the implementation of lay health workers in public health programs which have been echoed by other sources. Two particularly notable issues were those of: 1) power conflicts between lay health workers and trained health care professionals and 2) the potential to "undermine" the lay health worker's "indigenousness" through extensive technical training. The experience of a recent prenatal care intervention implemented in Arizona, *Comienzo Sano*, provides an example which reveals that such issues continue to be problematic. *Comienzo Sano* utilized an "empowerment" strategy, in which lay health workers were given considerable power to shape the specific objectives of the intervention and encouraged to seek "upward mobility." In evaluation of the program, it was found that a major structural barrier to this goal was competition, and even outright hostility, between the ambitious lay health workers (termed *promotoras* in this particular intervention) and health care professionals and administrators in the academic hospital providing clinical support for the program. When the program was ultimately integrated into the local county health department, a process which further shifted the emphasis of the program towards a biomedical model and away from a sociocultural one, these conflicts became increasingly evident.[84]

Issues of power and politics are not unique to the implementation of lay health worker programs. In fact, one of the most vocal objections raised against the principle

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[83]Giblin, pp. 361-8.
[84]Meister, et al., p. 50.

of culture brokering has been the claim that power inequities are inherent when culture brokers are imported from outside of a cultural minority community. Maria Borrero and colleagues have developed a prominent critique of the culture broker model and have provided an alternative strategy of action research training, similar to that proposed above by Giblin. Borrero, et al. argue that the culture broker, particularly the anthropologist, is continuously negotiating between dual alliances with "power brokers" on the one hand and the cultural minority community on the other. Because the culture broker is, by definition, a professional who is part of the medical establishment and not a member of the underserved community, s/he is continuously at risk of losing touch with that community. As a result, the specific needs of the underserved community are often misrepresented or neglected altogether by the culture broker, who is also often preoccupied with his/her own research ambitions. Borrero, et al. contend that the action research training approach which they offer has the potential to circumvent the problems intrinsic to the traditional culture broker intervention. In essence, they outline a model in which the roles of the lay health worker and the culture broker are brought into closer proximity to one another through the creation of a new entity, the *community researcher*. In their model, this community member serves both as a community advocate and as a trained ethnographic researcher.[85]

Although this action research approach has not yet been widely applied, on a theoretical plane, it is elegantly appealing for a number of reasons. In principle, a unification of the concepts of the lay health worker and the culture broker could serve as a vehicle through which the often competing strains of thought which have contributed to principles of culturally competent care might also be united. A consolidation of the often divergent theories and practices of medical anthropologists, public health researchers, transcultural nurses, and others participating in discourse in this area seems

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[85]Borrero, MG, Schensul, JJ, and Garcia, R. "Research based training for organizational change," Urban Anthropology, 11(1), 1982, pp. 129-53.

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long in coming. It is hard to deny that inter- and intra-professional competition have been a major counterproductive force in efforts to develop concepts of culturally relevant care at the individual practitioner level. The extent to which cooperative efforts can begin to overshadow this competition will have profound implications on the future development and proliferation of principles of cultural competency.

Bilingualism--A Brief Discussion:

The above approaches can be generally viewed as "bicultural" or "multicultural" approaches to cultural competency at the individual practitioner level, because they tend to view cultural systems as entire integrated systems. Another important strain of culturally competent care which has relevance to the individual practitioner level, but has not been discussed to this point, is that of bilingualism (or multilingualism). While it is beyond the scope of this paper to develop a full discussion of the theoretical foundations of principles of bilingualism, and the associated concepts of language translation and language interpretation, a brief mention of this large area of discourse is necessary because most definitions of culturally competent care include bilingual service provision as an important element. Furthermore, whereas the penetration of culture brokering and lay health advisor interventions has likely been minimal in the health care system as a whole, the utilization of bilingual services is well established and widespread.

From a Kleinmanian perspective, an ideal clinical encounter would include a practitioner who is not only fluent in the language of the patient, but also knowledgeable of the cultural subtleties of the use of language in a health care setting. However, in practice, the availability of bilingual and multilingual health professionals is relatively uncommon in most clinical contexts. Furthermore, it has been observed that an individual's bilingual capacity does not necessarily correlate with his or her bicultural capacity, particularly when it relates to negotiating between the patient's culture and the

culture of the medical system.[86] For example, it has been demonstrated that language in and of itself has the potential to affect the clinical presentation of a disease or illness.[87] In order to clarify these limitations of bilingualism with respect to biculturalism, the concepts of *translation* and *interpretation* have been introduced. Translation is generally defined as the act of exchanging words from one language to another, whereas interpretation is considered a more complex activity in which connotative meanings are also transmitted between parties.

Because adequate availability of bilingual and bicultural health professionals remains "a distant dream," as Frank Acosta and Martha Cristo have portrayed it,[88] the use of alternative means of negotiating language barriers has been necessary. For example, a few sources have commented on the use of family members or other conveniently available volunteers as interpreters. However, few would argue that the exclusive use of such *lay interpreters* to translate language is very problematic. Beyond the fact that the ad hoc use of untrained interpreters is unacceptably haphazard with respect to the quality of information transmission,[89] the inappropriateness of using family members as communication conduits in times of extraordinary emotional stress and grief has been discussed.[90] Given the serious shortcomings of utilizing lay interpreters, it is not surprising to find that an approach which has been adopted in a variety of health care settings has been the use of professional translators and/or interpreters. The most widely discussed use of translators and/or interpreters has been in mental health service provision, in which rates of misdiagnosis have been particularly

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[86]Haffner, L. "Translation is not enough. Interpreting in a medical setting," Western Journal of Medicine, 157(3), 1992, pp. 255-9.
[87]Del Castillo, JC. "The influence of language upon symptomatology in foreign-born patients," American Journal of Psychiatry, 127(2), 1970, pp. 242-4.
[88]Acosta, FX and Cristo, MH. "Development of a bilingual interpreter program: An alternative model for Spanish-speaking services," Professional Psychology, 12(4), 1981, p. 474.
[89]Marcos, LR. "Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients," American Journal of Psychiatry, 136(2), 1979, pp. 171-4.
[90]Haffner.

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high when language barriers between patients and clinicians have been present.[91] Beyond the use of translators and/or interpreters a small number of alternative approaches for addressing language barriers have been developed. For example, methods for developing and evaluating bilingual questionnaires for use in specific clinical contexts have been presented.[92] The use of intensive language courses with content specific to medical care has also been proposed.[93]

The use of translators, interpreters, and alternative formalized means of providing rapid communication between health care practitioners and patients has in no way been a panacea. A number of reports have emerged in past years which have documented the problems with using third-parties as language conduits in clinical transactions. In particular, it has been noted that use of either translators or interpreters greatly increases the likelihood that information will be omitted, added, condensed, or substituted.[94] The use of interpreters can not only result in patients "feeling less understood,"[95] but can also result in significantly decreased reliability of the information transmitted.[96] While inadequate reliability of information transmitted through translators has been demonstrated for a number of non-English languages, a recent report provides evidence that miscommunication is significant in the provision of

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[91]Westermeyer, J. "Working with an interpreter in psychiatric assessment and treatment," Journal of Nervous and Mental Disease, 178(12), 1990, pp. 745-9. The author cites a number of anectodal examples of cases in which (likely) preventable suicides occurred because of diagnostic failures on the part of clinical mental health professionals.

[92]Hendricson, WD, et al. "An approach to developing a valid Spanish language translation of a health-status questionnaire," Medical Care, 27(10), 1989, pp. 959-66; Nasr, I, et al. "Use of a bilingual medical history questionnaire in the emergency department," Annals of Emergency Medicine, 22(5), 1993, pp. 824-8.

[93]Binder, L, et al. "Development, implementation, and evaluation of a medical Spanish curriculum for an emergency medicine residency program," Journal of Emergency Medicine, 6(5), 1988, pp. 439-41.

[94]Vasquez, C and Javier, RA. "The problem with interpreters: Communicating with Spanish-speaking patients," Hospital and Community Psychiatry, 42(2), 1991, pp. 163-5.

[95]Kline, F, et al. "The misunderstood Spanish-speaking patient," American Journal of Psychiatry, 137(12), 1980, pp. 1530-3.

[96]Berkanovic, E. "The effect of inadequate language translation on Hispanics' responses to health surveys," American Journal of Public Health, 70(12), 1980, pp. 1273-6.

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health care to certain African-American populations as well.[97] Just as there have been no simple solutions to the inherent problems of using culture brokers in negotiating the cultural differences of patients and practitioners, there are no simple solutions to the limitations of using third-parties in negotiating linguistic differences. However, it has recently been proposed and demonstrated that closer collaborations between health care professionals and interpreters can at least partially alleviate these shortcomings.[98]

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[97]Brooks, TR. "Pitfalls in communication with Hispanic and African-American patients: Do translators help or harm?," Journal of the National Medical Association, 84(11), 1992, pp. 941-7.

[98]Hatton, DC. "Information transmission in bilingual, bicultural contexts," Journal of Community Health Nursing, 9(1), 1992, pp. 53-9; Hatton, DC and Webb, T. "Information transmission in bilingual, bicultural contexts: A field study of community health nurses and interpreters," Journal of Community Health Nursing, 10(3), 1993, pp. 137-47.

Chapter 2: The Community-Based Organization Level

Theoretical Basis of Interventions:

Work in the area of cultural competency at the level of the community-based health organization has been less grounded in academic theory than that at the patient-practitioner level. Instead, it has tended to pursue goals of a more socially activist nature. In large part, this can be attributed to the fact that most research and interventions at this level have emerged from social science and health care areas which are predominately applied--such as social work, public health, and mental health-- rather than from disciplines which are primarily theoretical. In other words, this work has frequently been the direct product of political action and policy level interventions. Furthermore, much of this work has developed out of immediate necessity in communities that would otherwise be underserved or excluded by the health care system. While a large component of the work in this area has utilized sophisticated quantitative and qualitative approaches in developing generalizable theories for effective interventions, the majority of work has been very idiosyncratic with respect to the particular health issues in a given community of study. As a result, one finds that the development and application of theoretical models has at times been inconsistent and non-generalizable.

Another feature prominent in community organization level interventions is that, unlike those at the patient-practitioner level, they have by and large avoided attempts to isolate cultural variables affecting health access and utilization from economic, political, and demographic ones. However, this avoidance of the *cultural factors* versus *socioeconomic factors* dilemma does not necessarily reflect an active process. It can instead be explained historically by the fact that many of the current theoretical models for developing culturally competent services at the community level have a direct lineage in approaches developed in the 1960s and 1970s which viewed ethnicity and

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socioeconomic status, rather than cultural difference, as the primary denominators for health underservice in this country. Hence, many of the present models of cultural competency at the community level simply represent an adaptation of older models for social change--now emphasizing the aspects of those approaches that are most consistent with the current paradigm, which focuses on increasing communication across cultures as the primary vehicle for reducing inequities in health status between groups. As a result, approaches at the community organization level have often fused and integrated components of those patient-practitioner level interventional strategies discussed above with interventions which are more rooted in public health and preventive health program strategies developed long before the terms cultural competency and cultural sensitivity came into vogue.

While there has, on the one hand, been considerable movement to integrate concepts of culturally sensitive, competent, etc. approaches to health care, it is also true that from one case to another there are often fundamental differences in the theoretical motivations behind developing particular interventions. For example, one can essentially divide the recent impetus for creating community level interventions into two distinct philosophies: 1) that which views culture as a source of *alternative health beliefs*, and 2) that which views culture--or, more precisely, cultural minority status--as a *barrier* to access and utilization of the mainstream allopathic medical system.[99] The former approach is highly consistent with models for addressing health-culture issues which were developed at the practitioner-patient level (i.e. adopting a Kleinmanian view of culture). The latter reflects a more pragmatic view of culture, and is largely derived from philosophies developed in the 1960s and 70s which viewed variables such as poverty and race as the primary indicators of inadequate health access for underserved groups (and, as discussed in the previous paragraph, these variables have tended to become

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[99]Stone, L. "Cultural influences in community participation in health," Social Science and Medicine, 35(4), 1992, p. 410.

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incorporated into the less traditional definition of culture which has frequently been utilized in the 1980s and 90s).

Because of the applied nature of the theoretical foundations for what is currently considered community organization level cultural competency, it is perhaps most useful to summarize the models which have been developed by looking at a specific example. Community mental health is a field in which the evolution of such models has been most active, and will be used as a prototype to illustrate the historical development of current theories. As with the development of community-based health interventions in other areas, those in mental health can be traced back to federal legislation which resulted from changes in the social climate of the 1960s. In the United States, accessibility to mental health services became a federal government priority with the passage of the Community Mental Health Centers Act of 1963. This legislation established a network of community mental health centers through the creation and consolidation of funding as well as informational resources. Following passage of this legislation, mental health research in the 1960s and 1970s increasingly pointed to ethnic and cultural minority status as primary indicators of differential mental health service access and utilization,[100] as well as differential mental health diagnoses and treatment.[101] The largest epidemiologic mental health study of this type was conducted by Stanley Sue and colleagues in the mid-1970s. Sue, et al. found significant differences in utilization patterns, lengths of treatment, and other indicators of mental health access between Asian-American, African-American, and Latino populations, relative to middle-class White populations.[102] Responding to this and other evidence, in 1978, the President's

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[100]Andrulis, D. "Ethnicity as a variable in the utilization and referral patterns of a comprehensive mental health center," Journal of Community Psychology, 5, 1977, pp. 231-7.
[101]Yamamoto, J, James, Q, and Palley, N. "Cultural problems in psychiatric therapy," Archives of General Psychiatry, 19, 1968, pp. 45-9; Simon, RJ, et al. "Depression and schizophrenia in hospitalized black and white mental patients," Archives of General Psychiatry, 28, 1973, pp. 509-12.
[102]Sue, S. "Community mental health services to minority groups: Some optimism, some pessimism," American Psychologist, 32, 1977, pp. 616-24.

Commission on Mental Health refined the focus of community mental health efforts upon the specific inadequacies of the mental health system to respond to the needs of underserved groups in society--particularly ethnic and cultural minority populations.

Preceding and following such legislation were numerous proposals for reducing disparities in mental health through interventions at the community level. Because of the community-based structure which had evolved within the American mental health system, these proposals almost invariably used the community organization as the functional unit for intervening. Nonetheless, there was considerable variation between the recommended approaches regarding the degree to which interventions from other levels (i.e. the patient-practitioner level and the administrative/policy level) were emphasized, as well as the degree to which strictly cultural versus other variables were addressed. While common themes were apparent through most of the proposals, many were specific to particular minority groups or to specific underserved communities within such groups. Responding to such variation, Nolan Zane and colleagues developed a useful model for summarizing and beginning to integrate the many proposed interventions which were developed for community mental health provision in underserved populations.[103] Their approach separated community level interventions into six domains: 1) "matching" and "fitting" of services, to respond to the social and cultural idiosyncrasies of a particular community; 2) integration and linkage of relevant services within the community (e.g. mental health with other social services); 3) efficient utilization of services, focusing upon prevention efforts and efforts incorporating natural support systems; 4) comprehensive services at the individual, family, organizational, and social system levels (i.e. integration of services at these levels); 5) community control of services and administrative accountability to the community; and 6) "knowledge

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[103]Zane, N, et al. "Service system models for ethnic minorities," ed. Snowden, LR, in Reaching the Underserved: Mental Health Needs of Neglected Populations, Beverly Hills, Sage Publications, 1983, pp. 229-58.

development and utilization" (i.e. research, promotion, and adoption of innovative models).

The language used within the model proposed by Zane, et al., as well as those varied interventional strategies which it was derived from, frequently included terms such as culturally sensitive and culturally appropriate. However, cultural sensitivity and related concepts were discussed as *components* rather than the *primary objectives* of this and similar models. Initially, cultural sensitivity was used almost exclusively within the mental health literature to describe service interventions that emphasized the patient-practitioner encounter (i.e. to refer to those theories and approaches described in the previous section). However, as references to the significance of culture in modifying health care interactions became more common in academic literature on the subject of mental health for the underserved (as well as in other areas), the use of terms such as cultural sensitivity was expanded. Terms like cultural sensitivity and cultural competency were increasingly used as unifying concepts, forming an umbrella under which all of the various approaches to improving mental health services for underserved populations at the community level could be included. Eventually, the entire model of Zane, et al. was included under the rubric of culturally competent/culturally sensitive care. For example when Cross, et al. released the groundbreaking monograph "Towards a Culturally Competent System of Care" in 1989 they presented a model of culturally competent care at the community which was nearly identical to (and referred specifically to) the content of the work of Zane, et al.[104]

On the surface, this process may simply be viewed as a change in the preferred language for describing a set of interventions, reflecting the changing political climate of different periods. However, on a deeper level it has resulted in a transformation of the working definition of culture to include not only the vertically transmitted behaviors and beliefs of a particular group, but also the more generalized socioeconomic milieu of a

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[104]Cross, et al., pp. 28-32.

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particular underserved community. Because this more utilitarian definition of culture has not been universally accepted between and within the various health care related disciplines in which culturally competent care is currently discussed, the question of whether significant inconsistencies and incompatibilities exist between the various models for developing this type of care is begged once again. While such issues are critical, a review of the health care literature finds that examples of efforts to address them directly are few and far between.

Beyond the general model for culturally competent health service provision at the community agency level proposed by Zane, et al., and later Cross, et al., there have only been a few attempts to more specifically elucidate the components of this concept. One notable effort was made by Richard Dana and colleagues in Portland, Oregon in 1992, to develop a "checklist" of criteria for culturally competent care in social service agencies. Dana, et al., after reviewing a vast bibliography of literature discussing cultural perspectives on mental illness and well-being, identified a subset of notable works which presented interventions for cultural minority groups. Analysis of this subset of papers found that characteristics cited most frequently included: "resource linkage" (linkages of agencies with existing community organizations other resources within the community served), bicultural staff, bilingual staff, localization in minority communities, use of *natural helpers/systems*, community advisory and control roles, incorporation of traditional customs and family roles into the intervention, an educational component to the intervention, use of minority paraprofessionals or culture brokers, an evaluation plan or tool, and flexible hours and appointments.[105] The checklist which resulted from this research was applied in at least one instance, and was evaluated for concurrent validity with the results of an in-depth observer analysis.[106]

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[105]Dana, RH, Behn, JD, and Gonwa, T. "A checklist for the examination of cultural competence in social service agencies," Research on Social Work Practice, 2(2), 1992, pp. 220-33.
[106]Dana, RH and Matheson, L. "An application of the agency cultural competence checklist to a program serving small and diverse ethnic communities," Psychosocial Rehabilitation Journal, 15(4), 1992, pp. 101-5.

The effort of Dana and his co-workers represents one of the few endeavors to not only synthesize a general definition of cultural competency, but to also validate this definition through an analysis of the specific ways the term is utilized in practice. Although there were plans to expand and further disseminate this work through additional research, such efforts were, unfortunately, eventually abandoned due to funding issues.[107]

To this point, the discussion of the development of current theories for culturally competent care at the community organization level has focused exclusively upon community mental health and has used the model proposed by Zane, et al. as a prototype. It should be acknowledged that additional models for culturally sensitive/competent care at the community level have been provided, which offer more limited perspectives. For example, models have been proposed which focus exclusively upon providing such care to a single cultural minority group.[108] Henrietta Bernal has also recently offered a model of culturally relevant care which emphasizes the role of transcultural nurses as organizers of such care.[109]

While the evolution of concepts of community level culturally competent care has been particularly evident in the field of mental health, other disciplines have also contributed to and influenced the present discourse in this area. Two other areas in which community level interventions have been extensively discussed and developed are the non-mutually exclusive areas of international health and preventive health. The influence of the former will not be discussed in any depth here as this paper's focus is limited to developments in the United States. Nonetheless, it should be acknowledged that there has been abundant discussion, at numerous levels, of the concepts of cultural sensitivity and cross-cultural health as they relate to the specific contexts of health and

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[107]Personal communication with Richard H. Dana, November, 1993.

[108]Campinha-Bacote, J. "Community mental health services for the underserved: A culturally specific model," Archives of Psychiatric Nursing, 5(4), 1991, pp. 229-35.

[109]Bernal, H. "A model for delivering culture-relevant care in the community," Public Health Nursing, 10(4), 1993, pp. 228-32.

culture in cultural minority communities in other parts of the world. Furthermore, this discussion has encountered many dilemmas similar to those discussed in other parts of this paper. Indeed, there has been considerable crossover and overlap between discussions in the realms of international health and preventive health within this country. For example, there have been a number attempts to develop universally applicable approaches (on an international scale) for developing community level interventions which emphasize the influence of culture on health.[110] In other instances, proposals have even been made to adapt whole models of community health from non-Western societies into minority communities in the United States.[111]

A few generalizations are worth noting with respect to the theoretical foundations driving the development of community level interventions in the area of preventive health. As with approaches developed for community mental health, there has been an emphasis upon pragmatism over philosophy, which has resulted in a blurring of distinctions between broad health objectives and specific cultural objectives. For example, because preventive health programs tend to have well defined treatment or educational goals (for example, consider the case of an intervention designed to increase levels of awareness of safer sex practices in a community in which the incidence of AIDS is increasing rapidly), interventions which have specifically been labeled culturally sensitive, competent, etc. have often used these concepts as *vehicles* for obtaining objectives rather than as *ends in themselves*. This approach is significantly different from the models proposed by Arthur Kleinman and others for modifying the practitioner-patient encounter, which did view the cultivation of cultural awareness and empathy as an exclusive goal. An advantage of such interventions is that because their objectives are usually highly discrete, success or failure can often be evaluated with respect to

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[110]Woelk, GB. "Cultural and structural influences in the creation of and participation in community health programmes," Social Science and Medicine, 35(4), 1992, pp. 419-24.
[111]Pearson, V. "Community and culture: A Chinese model of community care for the mentally ill," International Journal of Social Psychiatry, 38(3), 1992, pp. 163-78.

health outcome in a fairly straightforward manner (for example, in the case of a "culturally sensitive" AIDS education intervention, an increase in the prevalence of knowledge of safe sex practices might be assessed). However, by the same token, in taking such an approach it is usually difficult or impossible to conclusively extract the effects of the "cultural" intervention from other aspects of the intervention. In other words, these interventions generally are not evaluated with respect to whether cultural sensitivity was obtained, but instead tend to assume that it was implicit in the interventional design. As a result, the process of attempting to generalize the results of a particular intervention in this area is often problematic. These and other such problems will be further discussed below.

From Theory to Application of Community-Based Organization Level Models:

In the past twenty years, numerous community oriented strategies have been attempted in various geographic locations, frequently with goals that have been unique to health issues in the particular region of intervention. Many of these programs have been funded by federal dollars, such as those implemented in the 1980s under large block grants from the Maternal and Child Health Services (MCHS) division of the U.S. Public Health Service.[112] Those which have been evaluated in the medical literature have, almost without exception, been initiated by researchers in major academic centers. As discussed above, culturally sensitive/competent community-based programs have primarily emerged from the fields of preventive medicine (e.g. health education and outreach) and mental health services.

While these community-based interventions have overwhelmingly been small projects with very specific (as well as very limited) intents, a handful of fortunate projects have been conducted on moderately large scales with more ambitious goals of offering relatively comprehensive primary and outreach level culturally sensitive health

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[112]Hutchins, V and Walch, C. "Meeting minority health needs through special MCH projects," Public Health Reports, 104(6), 1989, pp. 621-6.

services. Not surprisingly, these larger projects have been much more successful in achieving and approaching the objectives in the six areas outlined by Zane, et al. and others as constituting culturally competent/sensitive care at the community service agency level. In particular, larger projects have tended to be more successful in accomplishing the goals of: linking various social and health services; integrating the services offered at different levels (individual, family, organization, and social system); conducting research and periodically disseminating the results of this research; and achieving relative sustainability and longevity of programs within the communities served.

In order to illustrate more specifically the manner in which moderately large scale interventions have been implemented, two of the most successful, well studied examples are worth examining: the Jackson Memorial Hospital-University of Miami School of Medicine Community Mental Health Program (CMHP)[113] and the Johns Hopkins Medical Institution-East Baltimore Health Promotion Program.[114] The former offers an example of a mental health services directed program which utilized more traditional definitions of culture and of culturally-based intervention. The latter is an example of a preventive health project which utilized a more pragmatic definition of culture and of culturally-based intervention. In both cases, a core of academic researchers worked to assess the perceived needs of a particular underserved cultural/ethnic minority community and to subsequently develop set of interventions to address those needs which fell under the terminology of culturally sensitive, appropriate, etc.

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[113]Weidman; Bestman; Lefley, HP and Bestman, EW. "Public-academic linkages for culturally sensitive community mental health," Community Mental Health Journal, 27(6), 1991, pp. 473-88.
[114]Levine, DM, et al. "A partnership with minority populations: A community model of effectiveness research," Ethnicity and Disease, 2(3), 1992, pp. 296-305; Levine, DM, et al. "Narrowing the gap in health status of minority populations: A community-academic medical center partnership," American Journal of Preventive Medicine, 8(5), 1992, pp. 319-23; Levine, D, et al. "Community-academic health center partnerships for underserved minority populations: One solution to a national crisis," Journal of the American Medical Association, 272(4), 1994, pp. 309-11.

The CMHP, which has also been known as the "Miami Model," was developed in the early 1970s by psychiatrists and researchers at the University of Miami. The effort was initiated and directed by Hazel Weidman (referred to in the last chapter for her work in developing the concept of culture brokering) and was initially funded privately by the Commonwealth Fund of New York. The primary impetus for the development of the program was the increasing realization in the mental health community, as discussed above, that cultural and ethnic minority status were primary indicators of differential mental health access, diagnosis, and treatment. Such problems were particularly true among Latino populations, and as a result, a handful of model proposals were presented.[115] Early on, the project was entitled the Health Ecology Project, and consisted of a mental health services needs assessment study of 500 families in the northwest section of Miami--an area populated largely by Black Americans and recent Cuban, Haitian, Puerto Rican and Bahamian immigrants.[116] This effort was eventually expanded into a federally funded mental health program (the CMHP) serving a community of 200,000 in the same section of Miami. In order to accomplish its goal of providing comprehensive, accessible, culturally appropriate mental health and other health services to this population, the CMHP developed seven "teams" of culture brokers and "indigenous mental health workers" for each of the major cultural/ethnic minority groups in the region served. Based upon its own qualitative and quantitative assessments of the specific needs of the targeted group, each "team" developed specialized approaches to offering services. In addition, a network of "mini-clinics" was developed throughout the service area to provide "culturally homogeneous" mental health, social, outreach, and recreational services. In

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[115]Abad, V, Ramos, J, and Boyce, E. "A model for delivery of mental health services to Spanish-speaking minorities," American Journal of Orthopsychiatry, 44(4), 1974, pp. 548-95; Padilla, A, Ruiz, R, and Alvarez, R. "Community mental health services for the Spanish-speaking/surnamed population," American Psychologist, 30, 1975, pp. 892-905.
[116]Weidman, H. "Falling-out: A diagnostic and treatment problem viewed from a trans-cultural perspective," Social Science and Medicine, 13B, 1979, pp. 95-112.

the development of programs, community advisory boards as well as informal community oversight were utilized.

Although it developed a number of innovative approaches, the CMHP utilized a relatively traditional definition of cultural variables. For example, the fact that members of a number of the cultural minority groups in the service area were largely recent immigrants was significant to the project's development on multiple fronts. One manifestation was the fact that non-Western health belief systems were prominent as well as dominant among many individuals in these groups. From a *culture as (potential) barrier to care* perspective, efforts to provide culturally sensitive Western mental health services to such individuals were directed at acknowledging the significance of these alternative health beliefs from a traditional anthropological perspective (for example, in developing awareness of the influences of so called "culture-bound syndromes" upon the mental health of individuals). From a *culture as ally in providing care* perspective, the CMHP developed innovative outreach strategies, allying existing community resources such as religious groups, traditional healers, and culturally unique patterns of extended family structure, in order to reach populations which would otherwise likely have never sought contact with Western mental health services. While the CMHP attempted to define culturally significant variables in the population served by using a more traditional, anthropology based definition of culture, other issues which it was forced to address were more difficult to categorize as purely cultural in nature. For example, the historical pattern of immigration among many Haitian immigrants in the early 1980s became a significant factor which had to be considered in developing interventions, as such individuals tended to be political and economic refugees. The resulting psychological stresses suffered by these individuals, while not strictly cultural in nature (by a traditional definition of culture as a vertically transmitted set of beliefs and behaviors, etc.), were of considerable significance in the mental health management of patients experiencing them.

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As the CMHP continued its work throughout the 1980s and into the 1990s, it eventually became a private, free-standing organization (the New Horizons CMHC). While still providing culture-specific treatments and services, it was transformed into a more traditional community mental health center structure (eliminating the community "teams" and "mini-clinics") during this process. In addition to resulting in its institutionalization, the success of the project also provided its academic organizers with opportunities to develop strategies for disseminating its results. Under a three-year NIMH funded project entitled the Cross-Cultural Training Institute for Mental Health Professionals (CCTI), the CMHP provided intensive workshop training for nearly 200 mental health professionals throughout the United States. Training strategies utilized included didactic materials, cultural immersion, experiential role-playing, and specific training in administrative development techniques. Beyond providing direct training, the program also conducted a variety of research projects, utilizing data obtained throughout its own development. Some of the results will be discussed below.

The Johns Hopkins Medical Institution-East Baltimore Health Promotion Program provides an example of a large, ongoing, multi-objective preventive health intervention which, in structure, is also highly consistent with the model of culturally competent community-based health care proposed by Zane, et al. The project, co-directed by David Levine, a public health physician, and Diane Becker, a public health nurse, has been self-described as a "community-academic medical center partnership." The project was conceived between 1974 and 1979, and was designed to test the hypothesis that a comprehensive, population-based intervention program, administered jointly by community leaders and organizations in partnership with an academic medical institution, would result in measurable improvements in the health status of the target minority population—a largely African-American, low income, inner-city

community of 150,000.[117] While the focus of the intervention was not exclusively upon addressing cultural aspects of health care in this community, its evolution brought together many components of what has frequently been accepted as constituting the current definition of community organization level culturally competent care.

The Johns Hopkins-East Baltimore Partnership provides an example of a community-based project which can, in certain respects, be contrasted with the CMHP example. Whereas the CMHP's goal of improving access to mental health services in the service area of the project was fairly broad and open-ended, with process oriented objectives, the Johns Hopkins-East Baltimore Partnership tended to develop more specific, outcome oriented objectives. For example, its goals have included: the development of educational and social support enhancing interventions for patients with hypertension and their families; the implementation of neighborhood-based programs to identify and control risk factors for smoking, diabetes, obesity, hypercholesterolemia, and other health problems found to be disproportionately common in the community served; and the development of a violence prevention program. In addition, the program developed formal arrangements for providing medical, nursing, and public health students with opportunities to work within the community served under university and community mentors. Although the program took on these multiple objectives as it expanded over time, each new component which was added was very discrete with respect to mechanism of implementation and proposed means of future evaluation.

The Johns Hopkins-East Baltimore Partnership also differs significantly from the CMHP example in that the culture of the population within the service area was relatively homogeneous. In this regard, it is very typical of the vast majority of culturally sensitive/appropriate interventions which have been developed at the community level,

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[117]Levine, et al. "Narrowing the gap in health status of minority populations: A community-academic medical center partnership."

almost all of which have focused upon the health-culture interface for a single minority group. While it is perhaps not surprising to find that community level interventions have overwhelmingly tended to focus upon a single health issue (or carefully limited set of health issues) in a relatively discrete cultural minority population, it is also important to acknowledge that there are inherent potential limitations to such an approach. One significant limitation is the problem of non-generalizability to other health care contexts. Whereas the CMHP attempted to develop a fairly universal approach to identifying and addressing culturally significant aspects of health in a culturally diverse community, the Johns Hopkins-East Baltimore Partnership developed specific interventions based upon confronting the high incidence of certain conditions within a particular minority community. While the latter can be seen as representing a more pragmatic approach, in which the specific objectives of the intervention resulted in the adaptation of a less traditional view of cultural variables (e.g. targeting broad social and economic variables in its design), its intrinsically idiosyncratic nature also represents a barrier to extrapolating the success or failure of interventions to other health-culture interfaces. This issue will be discussed further below.

A prominent aspect of both the CMHP and the Johns Hopkins-East Baltimore Partnership throughout their development was considerable success in achieving the goal of "community ownership," one of the major conceptual requirements of the model set forth by Zane, et al. The Johns Hopkins-East Baltimore Partnership offers an example of a program which was particularly successful in accomplishing this goal. While the general rationale for developing the project was set forth by academic researchers, the project's development and implementation involved community participation immediately following its inception. For example, the initial community assessment of the program was conducted largely by a task force of community leaders and community representatives of neighborhood centers, churches, and community providers of care. As the program was expanded in subsequent phases of development in the

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1980s, community participation became increasingly prominent. For instance, the initiative of community leaders, particularly of church leaders, was the primary impetus for the creation of a collaborative preventive health referral network between Johns Hopkins and over 200 churches in the East Baltimore Service Area, entitled "Heart, Body and Soul."

The concept of "community ownership" which was a central component of the above examples has proven one of the most critical elements, if not the definitive test of success or failure, in the development and implementation of such interventions. It has been observed that the issue of sustainability in culturally competent/sensitive interventions is often neglected in their design.[118] Community participation in interventions, including community control and oversight, has been considered important for structural as well as economic reasons. The fact that community-based programs have, by and large, been funded by resources outside of the locales of intervention is significant. The capricious nature of federal funding for experimental and pilot programs has contributed greatly to the demise of numerous interventions. In addition, programs which have been imported to a community from an outside academic center have been demonstrated to have numerous inherent structural shortcomings, frequently resulting in poor outcomes. In such cases, researchers have found, for example, that community participation is often less than had been anticipated and that projects have proven much more labor intensive and costly than initially anticipated.[119] In addition, it has been observed that community-based programs which have been oriented to a specific clinical goal have often suffered from the myopia of their clinical emphasis, ultimately finding that adept administration of programs is as important, if not more

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[118]Ager, A. "The importance of sustainability in the design of culturally appropriate programmes of early intervention," International Disability Studies, 12(2), 1990, pp. 89-92.
[119]Doyle, E, Smith, CA, and Hosokawa, MC. "A process evaluation of a community-based health promotion program for a minority target population," Health Education, 20(5), 1989, p. 64.

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important than the task of providing culturally sensitive and appropriate services in the clinic.[120]

As the problem of sustainability of community-based programs has become increasingly prominent, various means for developing community participation and control over programs have been proposed. For example, methods for identifying and recruiting community leaders from underserved minority populations into preventive health programs have been developed and evaluated.[121] Recently, many of these strategies, which are not necessarily new approaches, have been subsumed under the concept of *community empowerment*. This concept, while certainly not exclusive to culturally competent/sensitive community interventions, has received considerable attention within the public health literature lately. For example, a major public health journal recently devoted two entire issues to a discussion of various conceptual and practical aspects of developing community empowerment strategies.[122] While it has been noted that the term empowerment has in recent years been a frequently used "buzzword" in a variety of contexts,[123] and that specific definitions of community empowerment have yet to be clarified,[124] a number of approaches have emerged in this area which have considerable overlap with those which fall under the rubric of culturally competent/sensitive care. Current efforts to further develop this concept include retrospective analyses of prototypical interventions to explicate the specific

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[120]Rodriguez, O, Lessinger, J, and Guarnaccia, P. "The societal and organizational contexts of culturally sensitive mental health services: Findings from an evaluation of bilingual/bicultural psychiatric programs," The Journal of Mental Health Administration, 19(3), 1992, pp. 213-23.
[121]Michielutte, R and Beal, P. "Identification of community leadership in the development of public health education programs," Journal of Community Health, 15(1), 1990, pp. 59-68; Flynn, BC, Rider, MS, and Bailey, WW. "Developing community leadership in healthy cities: The Indiana model," Nursing Outlook, 40(3), 1992, pp. 121-6.
[122]Health Education Quarterly, 21(2,3), 1994, pp. 141-417.
[123]Cottrell, R and Ciaramitaro, B. "The community's role in preventive health management: An empowerment model," Journal of Health and Social Policy, 5(1), 1993, p. 102.
[124]Israel, BA, et al. "Health education and community empowerment: Conceptualizing and measuring perceptions of individual, organizational, and community control," Health Education Quarterly, 21(2), 1994, p. 150.

characteristics of successful community empowerment initiatives[125] and the development of conceptual constructs and approaches for measuring the capacity of communities to be organized.[126] However, the development of strategies is often not a straightforward process. For example, it has been observed that even when community and outside groups agree upon overall objectives of a particular intervention, differences in agendas and approaches of multiple parties can result in conflicts that are destructive to the overall success of a health care intervention.[127]

While schemata for developing community ownership and empowerment within community-based programs currently evolve, the reality remains that the bulk of health programs implemented at this level have not emphasized such concepts. In contrast to the large CMHP and Johns Hopkins-East Baltimore Partnership examples discussed above, which were developed in a period in which funding for such projects was more readily available, most of the recent community level interventions implemented under the title of culturally competent, sensitive, etc. have been very small projects with limited resources. While the impetus for their creation is often based in grass-roots level need within communities, these smaller projects (at least those discussed in current health care literature) tend to be academically conceived experimental and research projects, with limited goals and often finite life spans. Nonetheless, while the relatively modest nature of such interventions may result in inherent disadvantages regarding long term sustainability and other factors, an advantage of smaller programs with limited objectives is that they can often also be evaluated more discretely in the short term. While larger programs often utilize multiple strategies simultaneously, making it difficult

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[125]Eisen, A. "Survey of neighborhood-based, comprehensive community empowerment initiatives," Health Education Quarterly, 21(2), 1994, pp. 235-252.
[126]Eng, E and Parker, E. "Measuring community competence in the Mississippi Delta: The interface between program evaluation and empowerment," Health Education Quarterly, 21(3), 1994, pp. 199-220; Braithwaite, R, Bianchi, C, and Taylor, S. "Ethnographic approach to community organization and health empowerment," Health Education Quarterly, 21(3), 1994, pp. 407-416.
[127]Flick, L, et al. "Building Community for Health: Lessons from a seven-year-old neighborhood/university partnership," Health Education Quarterly, 21(3), 1994, pp. 369-80.

if not impossible to isolate the effects of each on the outcome being measured, smaller programs have tended to utilize only one or two approaches at a time.

There are a number of areas of health care provision and outreach in which the development of smaller programs has been particularly active in the past several years. Not surprisingly, areas which have received considerable attention include those in which disparities in health among cultural minority groups have been demonstrated most prominently. For example, numerous culturally directed AIDS/HIV education programs, prenatal care programs, substance abuse programs, and dietary intervention programs have been proposed, designed, and implemented. Examples of areas in which interventions have been developed, or in which there has been considerable recent discussion regarding the need for such interventions, will be discussed briefly.

One such example is found in the domain of AIDS education. For many years now, it has been well known that the incidence of AIDS and HIV infection has increased at a disproportionately high rate in certain ethnic and cultural minority populations. It has also been noted that in the United States, public health education efforts regarding infectious diseases have a legacy of cultural insensitivity and overt racism.[128] Furthermore, compelling evidence has emerged which points to the interaction of cultural factors and numerous AIDS awareness variables. For example, studies have found that variations in cultural attitudes have been demonstrated with respect to condom use and other safe sex practices,[129] that significant variations in perceptions of risk among certain cultural minority groups exist,[130] and that these cultural differences may

[128]Thomas, SB and Quinn, SC. "The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV education and AIDS risk education programs in the black community," American Journal of Public Health, 81(11), 1991, pp. 1498-505.
[129]O'Donnell, et al. "STD prevention and the challenge of gender and cultural diversity: Knowledge, attitudes, and risk behaviors among black and Hispanic inner-city STD clinic patients," Sexually Transmitted Diseases, 21(3), 1994, pp. 137-48.
[130]Kalichman, SC, Hunter, TL, and Kelly, JA. "Perceptions of AIDS susceptibility among minority and nonminority women at risk for HIV infection," Journal of Consulting and Clinical Psychology, 60(5), 1992, pp. 725-32; Eskander, GS, Jahan, MS, and Carter, RA. "AIDS: Knowledge and attitudes among different ethnic groups," Journal of the National Medical Association, 82(4), 1990, pp. 281, 284-6; Wingood, GM and DiClemente, RJ. "Cultural, gender,

transcend ethnic culture.[131] In response to such data, numerous calls for culturally sensitive and appropriate community-based interventions have been made.[132] A variety of approaches and recommendations for developing culturally appropriate community-based interventions have been presented, some viewing cultural factors primarily as barriers to AIDS education efforts,[133] others attempting to identify methods of allying cultural factors in such efforts.[134] Numerous grants for developing such interventions have been provided by the Centers for Disease Control to national, regional, and ethnic-specific organizations in recent years.[135]

Despite the intensity of such discussions and the apparent availability of funding, the nature of such AIDS prevention and education interventions which have actually been presented in health related literature has, to date, been modest. Furthermore, the content of these interventions has varied considerably. Some factors which are likely responsible for such variation include: inconsistencies which exist

and psychosocial influences on HIV-related behavior of African-American female adolescents: Implications for the development of tailored prevention programs," Ethnicity and Disease, 2(4), 1992, pp. 381-8.

[131]Singer, M. "Confronting the AIDS epidemic among I.V. drug users: Does ethnic culture matter?," AIDS Education and Prevention, 3(3), 1991, pp. 258-83.

[132]Cassetta, RA. "Cultural competency: Essential to HIV/AIDS care and prevention," The American Nurse, 26(7), 1994, pp. 15; Stevenson, HC and White, JJ. "AIDS prevention struggles in ethnocultural neighborhoods: Why research partnerships with community based organizations can't wait," AIDS Education and Prevention, 6(2), 1994, pp. 126-39.

[133]Cruise, PL and Dunn, SM. "Ethnography and AIDS: A methodology for identifying culturally relevant risk-reducing behaviors," Journal of the Association of Nurses in AIDS Care, 5(4), 1994, pp. 21-7; Bor, R and Miller, R. "Developing AIDS counselling services: Problems and problem-solving," Journal of the Royal Society of Health, 110(4), 1990, pp. 126-9; Airhihenbuwa, CO, et al. "HIV/AIDS education and prevention among African-Americans: A focus on culture," AIDS Education and Prevention, 4(3), 1992, pp. 267-76.

[134]Marin, G. "AIDS prevention among Hispanics: Needs, risk behaviors, and cultural values," Public Health Reports, 104(5), 1989, pp. 411-5; Schinke, SP, et al. "African-American and Hispanic-American adolescents, HIV infection, and preventive intervention," AIDS Education and Prevention, 2(4), 1990, pp. 305-12; Pittman, KJ, et al. "Making sexuality education and prevention programs relevant for African-American youth," Journal of School Health, 62(7), 1992, pp. 339-44; Scrimshaw, SC, et al. "The AIDS Rapid Anthropological Assessment Procedures: A tool for health education planning and evaluation," Health Education Quarterly, 18(1), 1991, pp. 111-23.

[135]Holman, PB, et al. "Increasing the involvement of national and regional racial and ethnic minority organizations in HIV information and education," Public Health Reports, 106(6), 1991, pp. 687-94.

between recommended strategies; differences in definitions of culturally sensitive, appropriate, etc. which have been adopted; limitations on funding of projects; differences in the needs of particular communities; and the idiosyncratic interests and biases of individuals implementing these interventions. The following are examples of recently implemented AIDS prevention and education interventions self-described as culturally sensitive or appropriate. One program consisted of an evaluation of "culturally similar" versus "culturally dissimilar" AIDS education videos administered to African-American summer school students.[136] Another was an AIDS education project for African-American women which consisted of a 20 minute educational video "framed in a context specifically intended to increase cultural relevance" which was administered by an ethnically-matched presenter.[137] Another was a similar, but more intensive, specialized AIDS counseling program for impoverished African-American and Latina women utilizing videotapes, counseling with ethnically-matched and culturally knowledgeable nurses, the provision of stress reduction and coping information, the provision of social service referrals, and specific instruction on the utilization of condoms and needle disinfection.[138] Yet another project consisted of an AIDS education program for African-American college students which utilized "peer educator-mentors" to provide this education.[139] An obvious theme in the preceding examples has been a frequent reliance upon videotaped materials (a trend which may reflect funding limitations of these programs). Indeed, in response to such reliance on videotaped materials in AIDS education efforts, there has been one recent proposal describing a

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[136]Stevenson, HC and Davis, G. "Impact of culturally sensitive AIDS video education on the AIDS risk knowledge of African-American adolescents," AIDS Education and Prevention, 6(1), 1994, pp. 40-52.

[137]Kalichman, SC, et al. "Culturally tailored HIV-AIDS risk-reduction messages targeted to African-American urban women: Impact on risk sensitization and risk reduction," Journal of Consulting and Clinical Psychology, 61(2), 1993, pp. 291-5.

[138]Nyamathi, AM, et al. "Outcomes of specialized and traditional AIDS counseling programs for impoverished women of color," Research in Nursing and Health, 16(1), 1993, pp. 11-21.

[139]McLean, DA. "A model for HIV risk reduction and prevention among African American college students," Journal of the American College of Health, 42(5), 1994, pp. 220-3.

methodology for attaining greater consistency in their development.[140] Of course, on a broader level, the question is begged of whether such inherently restricted and generic interventions are accurate in describing themselves as "culturally sensitive" or "culturally appropriate."

A second example of an area in which there has recently been considerable attention paid to community-based programs focused on the significance of culture and cultural minority status in affecting health care is prenatal service provision. Increased rates of infant mortality, low birth-weight delivery, and maternal mortality have been documented among a variety of underserved groups.[141] Furthermore, evidence of inadequate prenatal service utilization and access among certain ethnic and cultural minority groups has been well established.[142] Barriers to utilization of such services which have been identified have included not only structural and socioeconomic factors (such as financial limitations or under-insurance)[143] but also individual psychosocial factors (such as fear and distrust of the medical system).[144] In addition, it has been demonstrated that family and social support factors are significant motivators of women in numerous ethnic groups for obtaining prenatal care.[145] While many strategies and interventions for increasing prenatal service utilization among underserved groups have emerged in recent years, only a handful have described themselves as culturally sensitive or culturally appropriate. The authors of this work have primarily been from

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[140]O'Donnell, L, et al. "Reducing AIDS and other STDs among inner-city Hispanics: The use of qualitative research in the development of video-based patient education," AIDS Education and Prevention, 6(2), 1994, pp. 140-53.

[141]Kleinman, JC. "Infant mortality among racial/ethnic minority groups, 1983-1984," MMWR CDC Surveillance Summary, 39(3), 1990, pp. 31-9; Koonin, LM, et al. "Maternal mortality surveillance, United States, 1979-1986," MMWR CDC Surveillance Summary, 40(2), 1991, pp. 1-13.

[142]Kogan, MD, et al. "Racial disparities in reported prenatal care advice from health care providers," American Journal of Public Health, 84(1), 1994, pp. 82-8.

[143]Poland, ML, Ager, JW, and Olson, JM. "Barriers to receiving adequate prenatal care," American Journal of Obstetrics and Gynecology, 157, 1987, pp. 297-393.

[144]Joyce, K, Diffenbacher, G, and Green, J. "Internal and external barriers to obtaining prenatal care," Social Work in Health Care, 9, 1983, pp. 89-96.

[145]Lia-Hoagberg, B, et al. "Barriers and motivators to prenatal care among low-income women," Social Science and Medicine, 30(4), 1990, pp. 487-95.

the fields of public health, preventive medicine, and community nursing. Although in general, such interventions have been fairly consistent in their design with the models and criteria set forth by Zane, et al. and Dana, et al. for the provision of culturally competent care at the community organization level, the degree to which specific approaches have been utilized has varied widely. Most have developed out of linkages with academic institutions, although a few have been relatively free-standing community projects.

Below are some examples of community-based prenatal interventions which have been recently described. The range of programs which have been developed for specific underserved communities include: a collaborative academic-community organization program for a low income Mexican-American population near the U.S.-Mexico border,[146] a nurse delivered prenatal program for recent immigrant women from Southeast Asia, funded by both private and federal MCHS sources,[147] an NIH supported pilot project to provide services to ethnic Hawaiian, Filipino, and Japanese women in rural Hawaii,[148] and a university-community clinic project for an inner-city community in Chicago.[149] Programs have also been implemented which have utilized nurse-midwifery practice as a vehicle for delivering pre- and peri-natal services in a self-proclaimed "culturally sensitive" manner.[150] In addition to such comprehensive prenatal care programs, efforts have been made to develop culture specific public health

[146]Carillo, J, Pust, R, and Borbon, J. "Dara a Luz: A perinatal care program for Hispanic women on the U.S.-Mexico border," American Journal of Preventive Medicine, 2(1), 1986, pp. 26-9.
[147]Mattson and Lew.
[148]Affonso, DD, et al. "Prenatal and postpartum care in Hawaii: A community-based approach," Journal of Obstetric, Gynecologic and Neonatal Nursing, 22(4), 1993, pp. 320-5.
[149]Bardack, MA and Thompson, SH. "Model prenatal program of Rush Medical College at St. Basil's Free Peoples Clinic, Chicago," Public Health Reports, 108(2), 1993, pp. 161-5.
[150]Dickinson, CP, Jackson, DJ, and Swartz, WH. "Making the alternative the mainstream. Maintaining a family-centered focus in a large freestanding birth center for low-income women," Journal of Nurse Midwifery, 39(2), 1994, pp. 112-8; Fullerton, JT, Palinkas, L, and Cavero, C. "Nurse-midwifery services in one multi-ethnic, underserved community," Journal of Health Care for the Poor and Underserved, 2(2), 1991, pp. 293-306.

messages promoting prenatal services among underserved populations.[151] Specific approaches utilized in such interventions have included various methods which have been components of recent definitions of culturally competent/sensitive community-based interventions. Strategies used include: lay health workers and "bicultural" community outreach workers,[152] translator and/or interpreter services,[153] written materials in non-English languages,[154] provision of transportation services,[155] culturally-directed health education services,[156] and cultural sensitivity education programs for health professionals.[157] While these programs all refer to themselves as culturally sensitive, appropriate, etc., the degree to which traditionally defined cultural factors have been addressed by each is highly variable. For example, the project for rural Hawaiian mothers cited above was fairly unique in its use of novel resources available within the community served. It incorporated three traditional health belief systems, *Ho'oponopono*, *Arreglo*, and *Naka Naori*, into services offered. In contrast, the project developed in Chicago offered no mechanisms for integrating aspects of existing cultural systems into the services it provided, and in fact utilized almost none of the services described by most current definitions of culturally competent care at the community organization level.

Another example of an area in which considerable attention has recently been focused upon the need for community level interventions directed at cultural variables is that of substance abuse education and treatment. The impetus for this phenomenon has been the observation by a number of studies that cultural factors influence drug abuse

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[151] Alcalay, R, Ghee, A, and Scrimshaw, S. "Designing prenatal care messages for low-income Mexican women," Public Health Reports, 108(3), 1993, pp. 354-62.

[152] Affonso, et al.; Carillo, et al.; Fullerton, et al.; Mattson and Lew; Warrick, LH, et al. "Evaluation of a peer health worker prenatal outreach and education program for Hispanic farmworker families," Journal of Community Health, 17(1), 1992, pp. 13-26.

[153] Affonso, et al.; Carillo, et al.; Fullerton, et al.; Mattson and Lew; Warrick, et al.; Dickinson, et al.

[154] Mattson and Lew.

[155] Dickenson, et al.; Bardack and Thompson.

[156] Carillo, et al.; Dickinson, et al.; Mattson and Lew.

[157] Bardack and Thompson; Mattson and Lew.

patterns,[158] and, moreover, that cultural barriers are significant in influencing treatment decisions among members of certain underserved groups.[159] Furthermore, it has been observed and documented that low rates of substance abuse program utilization among certain ethnic minority groups exist,[160] and that this phenomenon can be attributed in significant part to the fact that services are often not "culturally relevant."[161] As a result, discussion has developed around the need for culturally appropriate or culturally specific substance abuse programs for a number of groups in which there has either been: 1) a documented increased incidence of substance abuse (in particular, this has been well documented among certain Native American populations);[162] 2) a perception that cultural factors are significant in affecting substance use behavior;[163] or 3) a perception that culturally-based beliefs have negatively affected the utilization of substance abuse services.[164] While discourse in this area has been characterized by considerable urgency in its tone, it also emerges within a background of significant controversy. For example, discussion has emerged regarding the potential logistical and ethical problems in developing research methodologies for identifying cultural variables which are significant

[158]Westermeyer, J. "Cultural patterns of drug and alcohol use: An analysis of host and agent in the cultural environment," Bulletin on Narcotics, 39(2), 1987, pp. 11-27

[159]Singer; Cabaj, RP. "AIDS and chemical dependency: Special issues and treatment barriers for gay and bisexual men," Journal of Psychoactive Drugs, 21(4), 1989, pp. 387-93; Ja, DY and Aoki, B. "Substance abuse treatment: Cultural barriers in the Asian-American community," Journal of Psychoactive Drugs, 25(1), 1993, pp. 61-71.

[160]Longshore, D, Hsieh, SC, Anglin, MD, and Annon, TA. "Ethnic patterns in drug abuse treatment utilization," Journal of Mental Health Administration, 19(3), 1992, pp. 268-77.

[161]De Leon, G, et al. "Is the therapeutic community culturally relevant? Findings on race/ethnic differences in retention in treatment," Journal of Psychoactive Drugs, 25(1), 1993, pp. 77-86.

[162]Beauvais, F and LaBoueff, S. "Drug and alcohol abuse intervention in American Indian communities," International Journal of the Addictions, 20(1), 1985, pp. 139-71; Bachman, JG, et al. "Racial/ethnic differences in smoking, drinking, and illicit drug use among American high school seniors, 1976-89," American Journal of Public Health, 81(3), 1991, pp. 372-7.

[163]McKirnan, DJ and Peterson, PL. "Psychosocial and cultural factors in alcohol and drug abuse: An analysis of a homosexual community," Addictive Behaviors, 14(5), 1989, pp. 555-63; Perez-Arce, P. "Substance use patterns of Latinas: Commentary," International Journal of the Addictions, 29(9), 1994, pp. 1189-99; D'Avanzo, CE, Frye, B, and Froman, R. "Culture, stress and substance use in Cambodian refugee women," Journal of Studies on Alcohol, 55(4), 1994, pp. 420-6.

[164]Smith, DE, et al. "Cultural points of resistance to the 12-Step recovery process," Journal of Psychoactive Drugs, 25(1), 1993, pp. 97-108.

to the identification and treatment of substance abuse problems in particular communities.[165] Criticism has also been made of the manner in which ethnicity, a multidimensional concept which includes racial, cultural, and symbolic components, is often inappropriately utilized in developing such interventions.[166]

Culturally directed substance abuse prevention and treatment programs have generally focused upon individual ethnic minority communities which are at increased risk. For example, a number of culture-specific prevention programs have been developed for at-risk African-American youths and families. Strategies utilized have included the recruitment of churches and public schools as conduits for reaching populations and the implementation of family and peer support interventions.[167] In response to the observation that there has been considerable historical and cultural incongruity in traditional drug abuse programs, a model for offering substance abuse services in a manner which emphasizes African concepts of "consciousness, character, conduct, collectivity, competence, caring, and creed" has recently been proposed.[168] Given the fact that significantly higher rates of substance abuse have been demonstrated among Native Americans living on reservations, and that traditional substance abuse prevention and treatment programs have been largely ineffective in reaching these groups,[169] there have been a number of programs developed for providing services to

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[165]Perez-Arce; Moncher, MS, Holden, GW, and Trimble, JE. "Substance abuse among Native-American youth," Journal of Consulting and Clinical Psychology, 58(4), 1990, pp. 408-15.
[166]Cheung, YW. "Approaches to ethnicity: Clearing roadblocks in the study of ethnicity and substance use," International Journal of the Addictions, 28(12), 1993, pp. 1209-26.
[167]Maypole, DE and Anderson, RB. "Culture-specific substance abuse prevention for blacks," Community Mental Health Journal, 23(2), 1987, pp. 135-9; Van Hasselt, VB, et al. "Drug abuse prevention for high-risk African American children and their families: A review and model program," Addictive Behaviors, 18(2), 1993, pp. 213-34.
[168]Rowe, D and Grills, C. "African-centered drug treatment: An alternative conceptual paradigm for drug counseling with African-American clients," Journal of Psychoactive Drugs, 25(1), 1993, pp. 21-33.
[169]Beauvais, F, Oetting, E, and Edwards, R. "Trends in drug use of Indian adolescents living on reservations: 1975-1983," American Journal of Drug and Alcohol Abuse, 11(3-4), 1985, pp. 209-30; Beauvais, F, et al. "American Indian youth and drugs: 1975-1987--A continuing problem," American Journal of Public Health, 79(5), 1989, pp. 634-6.

Native American groups.[170] While such interventions have attempted to isolate cultural variables, and to ally such variables whenever possible, cultural diversity within the African-American and Native American communities have made these endeavors problematic.

In addition to community-based interventions developed in the above areas, there has been growing interest in applying concepts of culturally competent care in a number of other areas. For example, there has been recent discussion of the need for culturally appropriate dietary interventions.[171] Specific proposals and programs have been developed for culturally sensitive diet counseling and weight management for a number of groups.[172] Culturally appropriate smoking cessation interventions have also been developed and implemented.[173] As the use of the language of cultural competency

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[170]Beauvais, F. "An integrated model for prevention and treatment of drug abuse among American Indian youth," Journal of Addictive Diseases, 11(3), 1992, pp. 63-80; Beauvais and LaBoueff, "Drug and alcohol abuse intervention in American Indian communities"; Gilchrist, LD, et al. "Skills enhancement to prevent substance abuse among American Indian adolescents," International Journal of the Addictions, 22(9), 1987, pp. 869-79; Gurnee, CG, et al. "Substance abuse among American Indians in an urban treatment program," American Indian and Alaska Native Mental Health Research, 3(3), 1990, pp. 17-26.

[171]Kittler and Sucher; Hankin, JH and Wilkens, LR. "Development and validation of dietary assessment methods for culturally diverse populations," American Journal of Clinical Nutrition, 59(1 Suppl), 1994, pp. 198S-200S.

[172]Kumanyika, SK and Ewart, CK. "Theoretical and baseline considerations for diet and weight control of diabetes among blacks," Diabetes Care, 13(11), 1990, pp. 1154-62; Quatromoni, PA, et al. "Use of focus groups to explore nutrition practices and health beliefs of urban Caribbean Latinos with diabetes," Diabetes Care, 17(8), 1994, pp. 869-73; Shintani, T, et al. "The Waianae Diet Program: A culturally sensitive, community-based obesity and clinical intervention program for the Native Hawaiian population," Hawaii Medical Journal, 53(5), 1994, pp. 136-41, 147; Shintani, TT, et al. "Obesity and cardiovascular risk intervention through the ad libitum feeding of traditional Hawaiian diet," American Journal of Clinical Nutrition, 53(6 Suppl), 1991, pp. 1647S-1651S; Slonim, AB, Kolasa, KM, and Bass, MA. "The cultural appropriateness of the WIC Program in Cherokee, North Carolina," Journal of the American Dietetic Association, 79(2), 1981, pp. 164-8; Cousins; Kumanyika, SK, Morssink, C, and Agurs, T. "Models for dietary and weight change in African-American women: Identifying cultural components," Ethnicity and Disease, 2(2), 1992, pp. 166-75; Stowers, SL. "Development of a culturally appropriate food guide for pregnant Caribbean immigrants in the United States," Journal of the American Dietetic Association, 92(3), 1992, pp. 331-6

[173]Marin, G, et al. "Changes in information as a function of a culturally appropriate smoking cessation community intervention for Hispanics," American Journal of Community Psychology, 18(6), 1990, pp. 847-64; Perez-Stable, EJ, et al. "Evaluation of "Guia para Dejar de Fumar," a self-help guide in Spanish to quit smoking," Public Health Reports, 106(5), 1991, pp. 564-70.

becomes more well accepted, the scope of community-based interventions will no doubt expand into other areas as well.

Evaluation of Interventions at the Community-Based Organization Level:

Given the diversity of interventions which have been proposed and implemented at the community organization level, the issue of evaluation is a critical one. If concepts of culturally competent care at this level are to be distilled and made generalizable to other health care contexts, effective approaches must be separated from those which are less efficacious. While such assertions might seem straightforward in principle, in practice there are sizable stumbling blocks to accomplishing these ends. A significant barrier to this process is the fact that in many cases, adequate evaluations are simply not performed. Whether this is simply a manifestation of poor planning is uncertain. David Takeuchi and colleagues have proposed that the failure to perform program assessments may, in certain cases, actually be intentional on the part of program developers. They note that many programs are particularly susceptible to problems in implementation in their early phases, and that evaluating these programs early on might lead to negative findings (which could in turn endanger funding of these programs).[174]

While there are many cases in which programs have not been evaluated, a significant number of interventions in this area have included at least a limited mechanism for assessing the impact upon the targeted community. In a few instances, control groups have been available for study. By and large, the most commonly employed method for evaluating culturally directed community-based interventions has been outcome evaluation. Such an approach is logical, given that most such projects have been public health efforts with fairly discrete objectives. Furthermore, it is a particularly useful means of evaluation when only a single interventional strategy has been utilized. Outcome evaluation can also be a fairly simple process. Obtaining

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[174]Takeuchi, DT, Mokuau, N, and Chun, CA. "Mental health services for Asian Americans and Pacific Islanders," Journal of Mental Health Administration, 19(3), 1992, p. 240.

epidemiologic data on the effects of an intervention (such as changes in health education levels or health indices in the targeted community) provides a discrete, quantifiable measure of a program's impact.

Overall, it is difficult to make generalizations about the findings of outcome studies performed on community-based interventions which have been implemented under the heading of culturally sensitive, appropriate, etc. In part, this is reflection of differences in order of scale from one study to another. It is also a function of the great variation of health care contexts in which interventions have been implemented. Two examples which can be used to illustrate this point are the CMHP and the Johns Hopkins-East Baltimore Partnership, the two longest-lived interventions in this area.

The CMHP, which utilized a combined strategy of culture brokers, clinical staff education, and linkages with traditional health systems in the communities served, found a dramatic increase in the utilization of services by minorities (to an aggregate representation of 80% of the project's total caseload) and markedly decreased no-show and dropout rates among minority clients. The program also demonstrated increased client satisfaction levels.[175] These results were consistent with national and regional results over a similar period for other community mental health centers.[176] Nonetheless, a number of sources have emphasized that the results of the CMHP represent but a small cross-section of culturally appropriate mental health service efforts. A 1990 review of mental health service interventions for minority populations, performed by Cheung and Snowden, found that there was inadequate data to conclude that culturally sensitive programs were effective in improving minority utilization.[177] Furthermore, there have been some conflicting reports regarding the effects of certain culturally sensitive mental health service strategies. For example, a 1980 study by Wu and Windle

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[175]Lefley and Bestman.
[176]O'Sullivan, M. "Ethnic populations: Community mental health services ten years later," American Journal of Community Psychology, 17(1), 1989, pp. 17-30.
[177]Cheung, FK and Snowden, LR. "Community mental health and ethnic minority populations," Community Mental Health Journal, 26(3), 1990, pp. 277-91.

demonstrated that minority staffing of mental health programs was associated with increased minority participation.[178] Such data has been the rationale behind the utilization of patient-practitioner culture/ethnicity-matching strategies. However, a more recent study by Sue, et al. found that while ethnic match had a measurable impact on increased length of mental health treatment, it was not associated with improved treatment outcome.[179] Similarly, a 1986 study performed by Flaskerud, did not identify any statistically significant correlations between the availability of nine "culture-compatible" services and rates of mental health service utilization.[180]

The Heart, Body, and Soul component of the Johns Hopkins-East Baltimore Partnership presented its outcome results primarily in terms of changes in the control of high blood pressure in the community and in decreasing hypertension-related morbidity and mortality. In all three of these areas, the program showed fairly dramatic effects-- high blood pressure control was increased from 38% to 79% over a five year period, hospitalization rates were 19% in the study group (as compared to 31% in the control group), and hypertension related mortality was reduced by 65% relative to control.[181] While such results are encouraging, the extremely limited focus of such outcome measurements make it impossible to generalize the successes of the Johns Hopkins project to other health care contexts. For example, the Cole County Community-Based Health Promotion Program, a program which shared many of the same goals of the Johns Hopkins project (attempting to reduce levels of cigarette smoking, uncontrolled hypertension, and elevated serum cholesterol in an underserved, urban African-American community) had very different results. Despite the utilization of health

[178]Wu, I. "Ethnic specificity in the relationship of minority use & staffing of community mental health centers," Community Mental Health Journal, 16), 1980, pp. 156-68.
[179]Sue, S, et al. "Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis," Journal of Consulting and Clinical Psychology, 59(4), 1991, pp. 533-40.
[180]Flaskerud, J. "The effects of culture-compatible intervention on the utilization of mental health services by minority clients," Community Mental Health Journal, 22), 1986, pp. 127-41.
[181]Levine, D. "The results: Impact and outcome of patient education," Journal of Human Hypertension, 4), 1990, pp. 35-7.

outreach workers, a community advisory board, and alliances with community churches, the Cole County Program was unable to develop sustainable community ownership and did not achieve any of its outcome goals because of poor participation.[182]

The results of interventions which have been less comprehensive than the CMHP and the Johns Hopkins-East Baltimore Partnership have also been variable. For example, among AIDS education programs discussed in the previous section, results have been inconsistent. One study found a significant improvement between pre- and post-test AIDS knowledge scores in a culturally sensitive video intervention (relative to a "culturally dissimilar" video control).[183] Another found no significant changes in AIDS knowledge between a more culturally directed educational intervention and a traditional educational control (both of which also included the use of video materials).[184]

The small amount of evaluative data on the impact of culturally sensitive prenatal care programs currently supports the assertion that such programs do improve levels of participation, ease of delivery, and client satisfaction. For example, the Southeast Asian Health Project (SEAHP) demonstrated significantly increased levels of prenatal health care participation within the population served and improved client emotional well-being.[185] Anecdotal evidence from a pre- and peri-natal program for migrant farm worker families, utilizing lay health workers, demonstrated increased satisfaction and ease of delivery for participating women.[186] Whether such improvements in service utilization and satisfaction will also manifest as decreased infant mortality and rates of low birth-weight babies has yet to be demonstrated.

There is also some outcome-based evaluative data indicating that certain types of culturally directed substance abuse prevention and treatment programs are effective.

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[182]Doyle, et al.
[183]Stevenson and Davis.
[184]Nyamathi, et al.
[185]Mattson and Lew.
[186]Warrick, et al.

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A culture oriented treatment program serving a variety of ethnic minority populations found significantly reduced dropout rates.[187] Preliminary results from an educational intervention directed at Native American adolescents demonstrated increased substance abuse knowledge levels and interpersonal management skills.[188] However, a culturally tailored treatment program for a similar population revealed no notable improvements in sobriety outcomes.[189]

While outcome measures can be effective means of assessing a program's performance, the exclusive use of such measures in assessing the performance of an intervention labeled "culturally sensitive" or "culturally appropriate" can be problematic for a number of reasons. For one thing, the sole use of outcome measures in appraising the success or failure of a community-based program which is self-identified as culturally sensitive, appropriate, etc. assumes that the intervention was in fact primarily directed at addressing cultural issues. In some cases, such an assumption is not necessarily warranted. In other words, simply because an intervention was self-described by its designers as being culturally relevant does not make it culturally relevant. While this point may seem obvious, its importance cannot be emphasized enough. As the terminology of culturally competent health care has become increasingly widespread (or fashionable, as one might even go so far as to say), a number of examples have been presented in the literature of community-based interventions which were not in fact primarily culturally directed, but were, nonetheless, successful in causing either a change in levels of participation in a preventive health program or in knowledge levels regarding an important public health issue.

Another problem with the exclusive use of outcome measures to assess interventions is that this approach tends to assume that program success is best

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[187]Perez-Arce, P, Carr, KD, and Sorensen, JL. "Cultural issues in an Outpatient Program for stimulant abusers," Journal of Psychoactive Drugs, 25(1), 1993, pp. 35-44.
[188]Gilchrist, et al.
[189]Gurnee, et al.

appraised through clinical effectiveness. In fact, the success of culturally targeted interventions is often more critically linked to non-clinical aspects of program structure. Orlando Rodriguez and colleagues have recently commented on the frequent neglect of administrative and political issues in the development of such interventions:

> The assumption that culturally sensitive mental health programs can operate as if only clinical issues are involved, or muddle through, once launched, is overoptimistic. Failures in both assessing the context of the program and conceptualizing culturally sensitive treatment could bring the whole concept of culturally oriented treatment into disrepute.[190]

Rodriguez, et al. recommend that program evaluation include an assessment of internal leadership, administrative support, and the program's relationship with the surrounding health care community. They also present the possibility that inter-ethnic competition is a significant barrier to the implementation of some programs. The recommendations of Rodriguez, et al. have been echoed by others. Jaqueline Wallen has also commented upon the frequent myopia of community-based culturally directed interventions. She proposes that small programs which serve a particular minority community might benefit from entering into cooperative referral relationships with other organizations. Wallen also acknowledges that an inherent conflict of interests often characterizes the positions of program developers and administrators:

> Bureaucracies, by definition, have standardized policies, procedures, and regulations. Since these are designed to guarantee that all will be treated the same, it would seem that bureaucratization would counteract bias or prejudice in the treatment of clients. But if "standardization" reflects values and norms of a dominant group, then discrimination is inevitable. Multicultural, or pluralistic, approaches to providing culturally appropriate services to minorities reject the notion of standardized services and represent, in most cases, a threat to the status quo.[191]

Such issues will no doubt become increasingly significant in the evaluation of interventions as concepts of culturally competent care begin to proliferate into health care administration and policy discussions.

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[190]Rodriquez, et al., p. 221.
[191]Wallen, J. "Providing culturally appropriate mental health services for minorities," <u>Journal of Mental Health Administration</u>, 19(3), 1992, p. 293.

Chapter 3: Beyond Theory and Experiments--
Administration, Research, and Policy

In recent years, there has been an increasing discussion of possible applications of concepts of culturally competent care within the health care system at large. These discussions have evolved on a number of fronts. They have included not only academics, clinicians, and local community organizers, but health care administrators and national policy-makers as well. For example, there has been considerable discourse on the necessity for further expanding and creating research approaches and methodologies that will improve the identification of health care needs among ethnic minority populations. A major thrust of such efforts has also been directed at means for increasing the supply (the so-called "pipeline") of health care professionals from ethnic and cultural minority backgrounds. In addition, there have been activities underway seeking to broaden the application of those concepts and strategies of culturally competent care which were generally developed within theoretical and experimental contexts at the individual health professional and local community agency levels. These efforts have primarily developed in the public sector, as the result of local, state, or national health policy interventions. However, in the past several years, there has been a considerable amount of interest emerging from the private sector as well. The entry of new motivations into the quest for culturally competent care, which are driven as much by market forces as by issues of social justice, has implications which will certainly shape the future definitions of such care.

Having alluded to a number of issues which will no doubt have a dominant influence on the future direction of culturally competent health care discussions and programs, the purpose of this chapter will be to examine each of these areas in further depth. However, before doing so it will be useful to turn to a brief discussion of evidence and arguments which have been responsible for drawing attention to issues of cultural competency at these levels in recent years.

Background--Evidence of Differential Health Status Among Ethnic and Cultural Minorities and Implications:

At the levels of national and state policy-making, the major impetus for developing legislation and executive programs which are consistent with concepts of culturally competent care has been the emergence of relatively abundant data which points to cultural and ethnic variables as major determinants of differential health status and behavior. Indeed, at least one entire quarterly journal is currently devoted to the study of such correlations.[192] A large number of national and regional studies have established ethnicity to be an independent variable affecting the incidence of a broad range of diseases and health conditions. For example, among major disease categories, Latinos have been demonstrated to suffer a higher incidence of chemical dependency, diabetes mellitus, violence, and AIDS. Native Americans have been demonstrated to suffer a higher rate of chemical dependency, diabetes mellitus, infant mortality, and violence.[193] It has also been demonstrated that African-Americans in the United States suffer from an excess number of deaths due to a variety of health problems and diseases including cardiovascular disease, cancer, cirrhosis, infant mortality, diabetes, and homicide.[194] Regional studies have found even more troubling trends. For example, in Harlem, New York the life expectancy of a black male is lower than that of a male growing up in Bangladesh.[195]

Many efforts have been made to isolate the root causes of these increased rates of morbidity and mortality among ethnic and cultural minority populations. One recently published review by Jon Kerner and colleagues identifies four major sources of such differentials in health status among minority groups: 1) poverty and socioeconomic

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[192]Ethnicity and Disease, Lawrence, KS, Allen Press.

[193]Nickens, HW. "The health status of minority populations in the United States," Western Journal of Medicine, 155(1), 1991, pp. 27-32.

[194]Kumanyika, SK and Golden, PM. "Cross-sectional differences in health status in US racial/ethnic minority groups: Potential influence of temporal changes, disease, and life-style transitions," Ethnicity and Disease, 1(1), 1991, pp. 50-9.

[195]McCord, C and Freeman, HP. "Excess mortality in Harlem," New England Journal of Medicine, 322(3), 1990, pp. 173-7.

inequity, 2) increasing ethnic and cultural diversity in the United States, 3) the demonstrated connection between ethnic and racial diversity and poverty, and 4) limited availability and quality of primary care treatment to low SES populations.[196] The paper goes on to discuss ways in which cultural factors directly impact health promotion efforts as well as ways in which factors within the health care system itself hinder such efforts.

Kerner and colleagues identify three direct influences of culture and diversity impacting health status: 1) ethnic variation in disease incidence and mortality, 2) cultural variation in risk factor exposures, and 3) cultural variation in knowledge, attitude, and behavior. The first point is essentially a restatement of the observation of differential rates of disease incidence, whereas the latter two attempt to extricate the impact of culture on health more precisely. Examples of evidence cited to support the second argument include: reports of differences of diet which place African-Americans and Mexican-Americans at higher risk of cardiovascular disease and the demonstration that unacculturated Latin Americans consume increased quantities of alcohol. Examples cited to support the third component include: differences in AIDS risk knowledge, attitudes, and behaviors among African-Americans, Latinos, and Whites (some of the references were discussed earlier in this paper) and evidence of increased lead exposure among a subgroup of Mexican-Americans in the lower Rio Grande Valley resulting from folk remedies practiced within this population.

In addition to examining the direct effects of cultural factors on health status, Kerner, et al. also identify a number of structural factors which they argue are responsible for inadequate health promotion and health access among underserved minority communities. Such structural factors cited include: 1) the allocation of inadequate monetary resources and inherent difficulties in grant funding mechanisms, 2)

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[196]Kerner, JF, Dusenbury, L, and Mandelblatt, JS. "Poverty and cultural diversity: Challenges for health promotion among the underserved," Annual Review of Public Health, 14, 1993, pp. 355-77.

inadequate leadership within the health care system at large, and 3) the interaction of socioeconomic factors with variation in the quality of clinical services provided.

The paper by Kerner, et al. provides a useful summary of the background of current discussions of the health-culture interface at the level of the health care system as a whole. In these discussions, a prominent feature has been the emergence of a spectrum of thought regarding the etiology of disparities in health status among ethnic and cultural minority groups. On both ends of this spectrum are positions, which although not necessarily mutually exclusive, do occasionally compete with and oppose one another. On one end are proponents of the position that cultural factors within minority populations are the primary source of differential health status. On the other end are supporters of the notion that structural factors within the health care system, coupled with disparities in socioeconomic status among minority populations, are the primary sources of differences in the health of these populations. This potential polarization of thought is significant for the following reason. While many of the interventions for culturally competent health care which were developed at the individual practitioner and community-based organization levels have tended to emphasize the significance of cultural factors over structural and socioeconomic ones, the present tide of academic thinking tends to favor structural socioeconomic etiologies over purely cultural ones.

Evidence for socioeconomic and structural factors negatively impacting the health of cultural and ethnic minorities has been accumulating at a rapid rate in recent years. Perhaps the most prominent example of socioeconomic influences on health status for minority populations is the differential rate of health insurance among racial and ethnic minorities. Whereas health uninsurance among Americans is a problem in general, rates of uninsurance among African-Americans and Latinos are much higher than among Whites. A recent study found that 25% of African-Americans and 35% of Latinos were uninsured, as opposed to 15% of Whites. It also found that, relative to

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Whites, members of minority groups were dramatically overrepresented among Medicaid recipients.[197] Evidence for structural features within the health care system negatively affecting the health of ethnic and cultural minority populations has proven more difficult to tease out (one might also speculate that there has been a somewhat self-interested tendency among health care researchers to avoid studies examining such connections). Nonetheless, a handful of studies have found trends which are alarming to many within the health care system. For example, a 1988 study of 130 family practice residents in Ohio found that 82% felt that welfare benefits caused poor people to become dependent upon the system, and that 48% believed indigent women became pregnant and had babies to collect welfare support. In addition, 73% of residents felt that poor patients were more likely than others to miss appointments without canceling, 43% claimed that the poor were more difficult patients, and 41% believed that poor patients usually cared less than others about their own health status.[198] Another study, which was concerned with differential treatment outcomes, found that in an emergency medical unit at a major academic teaching institution, Hispanics were twice as likely as non-Hispanic Whites to receive no pain medication for long-bone fractures.[199]

Implications for Health Care Research:

As questions of the relative importance of cultural factors versus socioeconomic and structural factors in influencing the differential health status of minorities emerge, a growing discourse has evolved regarding the implications of such questions for health care research. Some proponents of cross-cultural research have tended to follow a basic philosophy that "more is better." They have advocated the general need for expanding

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[197]Short, PF, Cornelius, LJ, and Goldstone, DE. "Health insurance of minorities in the United States," Journal of Health Care for the Poor and Underserved, 1(1), 1990, pp. 9-24 , 28-30.
[198]Price, JH, et al. "Perceptions of family practice residents regarding health care and poor patients," Journal of Family Practice, 27(6), 1988, pp. 615-21.
[199]Todd, KH, Samaroo, N, and Hoffman, JR. "Ethnicity as a risk factor for inadequate emergency department analgesia," Journal of the American Medical Association, 269(12), 1993, pp. 1537-9.

means of disseminating results of all research studying the interactions of culture, ethnicity, and health status.[200] Few would disagree with the position that the need for more cross-cultural research is great. However, attention is increasingly being focused upon the relative appropriateness of specific methodologies for cross-cultural research. In this arena, there has been less agreement. Some have advocated a fundamental restructuring of methods for studying concepts of health behavior and health status among cultural and ethnic minority populations. Others have advocated following a more conservative path. The significance of such debates is considerable, given that inconsistencies and conflicts between approaches might ultimately serve to marginalize such research. Indeed, it has been observed that inconsistencies in data obtaining methodologies have already contributed to very significant problems in the interpretation of results of many epidemiologic studies on the health status of ethnic and cultural minority populations.[201]

One arena in which discussion has expanded recently has been that of considering the importance of the interface between the culture within the population under study and the culture of the research community itself. Some of this discussion was alluded to in the section of the first chapter of this paper discussing Arthur Kleinman's work. A number of authors have discussed not only the limitations of applying traditional research approaches to studying certain aspects of health within minority populations, but also the inappropriateness of using such methods. For example, it has been argued that the application of methods and techniques developed within a "dominant culture" to other cultural groups threatens the validity and generalizability of research conducted within these groups.[202] More specifically, it has

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[200]Solberg, LI. "Cross-cultural medicine and health care research," Family Practice Research Journal, 12(1), 1992, pp. 1-5.

[201]Kumanyika, p. 50; Hahn, RA and Stroup, DF. "Race and ethnicity in public health surveillance: Criteria for the scientific use of social categories," Public Health Reports, 109(1), 1994, pp. 7-15.

[202]Henderson, DJ, et al. "Toward culturally sensitive research in a multicultural society," Health Care for Women International, 13(4), 1992, pp. 339-50.

been observed that measurement equivalence within and between sociocultural and ethnic groups is very often assumed, but rarely tested.[203] It has also been argued that scientists trained within a positivist Western scientific framework often bring biases and perspectives which are foreign to the subjects of this research.[204] Furthermore, it has been argued that the resulting misunderstanding and mistrust between subjects and researchers contributes to data inaccuracy.[205] Still others have observed that the ethics of Western clinical research approaches are often inconsistent with the ethical expectations of cultural minority populations.[206] Such concerns are particularly significant when questions exist as to whether research might actually be damaging to the population being studied. A good recent example of this is the extensive psychiatric research which has been performed on refugee populations from Southeast Asia who suffer from mental health illnesses that resulted from torture and oppression in their homelands.

In response to these concerns and others, a number of proposals have been offered to make research more culturally competent. For example, it has been argued that relatively simple considerations in the design of survey studies, such as increased resource allocation and increased attention to preliminary investigations of sociocultural characteristics within a community, can greatly improve the quality of data obtained when studying minority groups.[207] Other sources have suggested that ethnographic and qualitative approaches might often be better suited than quantitative approaches in the evaluation (particularly in the initial evaluation) of health problems within a particular

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[203]Dressler, WW, et al. "Comparative research in social epidemiology: Measurement issues," Ethnicity and Disease, 1(4), 1991, pp. 379-93.
[204]Bracken, PJ. "Post-empiricism and psychiatry: Meaning and methodology in cross-cultural research," Social Science and Medicine, 36(3), 1993, pp. 265-72.
[205]Cassidy, CM. "Walk a mile in my shoes: Culturally sensitive food-habit research," American Journal of Clinical Nutrition, 59(1 Suppl), 1994, pp. 190S-197S.
[206]Christakis, NA. "Ethics are local: Engaging cross-cultural variation in the ethics for clinical research," Social Science and Medicine, 35(9), 1992, pp. 1079-91.
[207]McGraw, SA, et al. "Health survey methods with minority populations: Some lessons from recent experience," Ethnicity and Disease, 2(3), 1992, pp. 273-87.

minority community. It has been argued that such methods can avoid many of the

assumptions made by traditional quantitative data obtaining methodologies.[208]

Responding to such arguments, a number of models for performing research in a more

culturally appropriate manner have been proposed. In some cases, these models have

become fairly elaborate--as in the example of the "cube model" based "culturally

anchored ecological framework of research," which was recently proposed by Sasao and

Sue.[209]

Perhaps the area which has received the most attention among proponents of

culturally sensitive research has been the development of research instruments with

cross-cultural validity. Recently, such instruments have been proposed and developed

for health issues ranging from dietary assessment to the study of diarrhea and

dysentery.[210] Because of the heavy reliance upon the use of diagnostic instruments for

both research and clinical purposes in psychiatry, the development of diagnostic

categories and instruments with cross-cultural validity has been particularly

controversial in this field. Nowhere was this more evident than in the development in

the late 1980s and early 1990s of the American Psychiatric Association's <u>Diagnostic</u>

<u>and Statistical Manual of Mental Disorders IV</u> (DSM-IV), currently the most widely

used psychiatric diagnostic reference. One of the central arguments shaping this process

was the position that DSM-IV's immediate predecessors, DSM-III and DSM-III-R, were

prone to significant diagnostic bias, and even ethnocentrism, in both content and

application when applied to certain racial and cultural groups.[211] Numerous pleas were

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[208]Henderson; Cassidy.

[209]Sasao, T and Sue, S. "Toward a culturally anchored ecological framework of research in ethnic-cultural communities," <u>American Journal of Community Psychology</u>, 21(6), 1993, pp. 705-27.

[210]Casssidy; Nichter, M. "Use of social science research to improve epidemiologic studies of and interventions for diarrhea and dysentery," <u>Reviews of Infectious Diseases</u>, 13(4), 1991, pp. S265-71.

[211]Fabrega, H, Jr., et al. "DSM III as a systemic culture pattern: Studying intracultural variation among psychiatrists," <u>Journal of Psychiatric Research</u>, 24(2), 1990, pp. 139-54; Loring, M and Powell, B. "Gender, race, and DSM-III: A study of the objectivity of psychiatric diagnostic behavior," <u>Journal of Health and Social Behavior</u>, 29(1), 1988, pp. 1-22; Rogler, LH.

made to incorporate mechanisms for assessing inter- and intra-cultural variation into the new DSM diagnostic schemata,[212] and ultimately such efforts were at least partially realized in the published version of DSM-IV.

While considerable discussion has evolved around the development of culturally appropriate methodologies and instruments, in recent years attention has increasingly been drawn to questions of whether the very indicators of differential health status which have historically been relied upon are inappropriate (or at least inadequate) for current conceptualizations of health and illness. In particular, the concept of race has been greatly scrutinized. For example, it has been observed that the concept of race is the product of a non-scientific, socially constructed system which has historical roots in notions of group superiority and inferiority. Moreover, in its present utilization, it is a poor biological marker and an unreliable indicator of social and cultural characteristics within minority populations.[213] In addition, the use of categories of race and *ethnicity* (a term which is not, by current definitions, equivalent to race) has been highly variable and inconsistent, leading to critical problems in generalizability and compatibility between research efforts.[214] One of the most vocal critics of the common utilization by researchers of either race or ethnicity as the exclusive indicator of minority status with respect to health has been Nancy Krieger. Krieger has argued that in order to develop

"Culture in psychiatric diagnosis: An issue of scientific accuracy," Psychiatry, 56(4), 1993, pp. 324-7; Gaines, AD. "From DSM-I to III-R; Voices of self, mastery and the other: A cultural constructivist reading of U.S. psychiatric classification," Social Science and Medicine, 35(1), 1992, pp. 3-24; Eisenbruch, M. "Toward a culturally sensitive DSM: Cultural bereavement in Cambodian refugees and the traditional healer as taxonomist," Journal of Nervous and Mental Disease, 180(1), 1992, pp. 8-10.

[212]Fabrega, H, Jr. "Diagnosis interminable: Toward a culturally sensitive DSM-IV," Journal of Nervous and Mental Disease, 180(1), 1992, pp. 5-7; Lukoff, D, Lu, F, and Turner, R. "Toward a more culturally sensitive DSM-IV. Psychoreligious and psychospiritual problems," Journal of Nervous and Mental Disease, 180(11), 1992, pp. 673-82; Mezzich, JE, Fabrega, H, Jr., and Kleinman, A. "Cultural validity and DSM-IV," Journal of Nervous and Mental Disease, 180(1), 1992, p. 4; Stein, DJ. "Cross-cultural psychiatry and the DSM-IV," Comprehensive Psychiatry, 34(5), 1993, pp. 322-9.

[213]Williams, DR, Lavizzo-Mourey, R, and Warren, RC. "The concept of race and health status in America," Public Health Reports, 109(1), 1994, pp. 26-41.

[214]McKenney, NR and Bennett, CE. "Issues regarding data on race and ethnicity: The Census Bureau experience," Public Health Reports, 109(1), 1994, pp. 16-25; Hahn and Stroup.

more reliable theories of disease causation, alternative indicators of health underservice must be utilized in all public health and epidemiologic research efforts. She has proposed that socioeconomic status or "social class" data might serve as such an indicator, and has presented models for incorporating this data into health care research.[215] Nonetheless, in the interim, the fact remains that race and ethnicity continue to be the most widely and exclusively used measures of sociocultural minority status.

Health Care Manpower Issues:

Any discussion of cultural competency within the American medical system would be incomplete without at least briefly discussing recent efforts to address the inadequate representation of ethnic and cultural minorities in the health care professions. While some might argue that a discussion of health manpower issues is tangential to discourse on cultural competency, the position taken here is that such a discussion is in fact critical to understanding the present state of efforts to develop a culturally competent health care system. A central component of cultural competency at the level of the health care provider organization is the principle that the professional ranks of the organization be representative of the ethnic and cultural diversity of the population served. This goal is difficult if not impossible for most organizations to achieve, given that the supply of minority health professionals has historically been inadequate. For example, in the past quarter-century shortages of African-Americans and Latinos among physicians, dentists, optometrists, pharmacists, public health

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[215]Krieger, N. "The making of public health data: Paradigms, politics, and policy," Journal of Public Health Policy, 13(4), 1992, pp. 412-27; Krieger, N. "Analyzing socioeconomic and racial/ethnic patterns in health and health care," American Journal of Public Health, 83(8), 1993, pp. 1086-7; Krieger, N and Fee, E. "Social class: The missing link in U.S. health data," International Journal of Health Service, 24(1), 1994, pp. 25-44; Krieger, N, et al. "Racism, sexism, and social class: Implications for studies of health, disease, and well-being," American Journal of Preventive Medicine, 9(6 Suppl), 1993, pp. 82-122; Krieger, N. "Overcoming the absence of socioeconomic data in medical records: Validation and application of a census-based methodology," American Journal of Public Health, 82(5), 1992, pp. 703-10.

workers, and registered nurses have been consistently demonstrated.[216] While efforts to correct these shortages have emerged in a number of professional disciplines, policies have been pursued most vigorously in the area of physician work force reform. Given the additional fact that ethnic minority underrepresentation has been more apparent among physicians than any other health professional category, the following discussion will emphasize policies and interventions directed at increasing the number of ethnic minority physicians.

In 1970, the Association of American Medical Colleges (AAMC), the major policy-making body for all American medical schools, established an Office of Minority Affairs. One of the primary motivations for this action was the recognition that certain minority groups, particularly Blacks and Hispanics, were greatly underrepresented among medical school graduates and practicing physicians. In subsequent years, the AAMC pursued an aggressive policy of: 1) recruiting minorities to apply to medical schools and 2) reevaluating and modifying admissions policies of medical schools. While this approach posted early successes in increasing the proportion of underrepresented minorities (URMs) in medical schools, a leveling trend was observed by the late 1980s.[217] A 1988 study by the Council on Graduate Medical Education (COGME), a division of the U.S. Public Health Service, found that while African-Americans, Latinos, and Native Americans constituted 22% of the total U.S. population, they comprised only 10% of entering medical students, 7% of practicing physicians, and 3% of medical faculty.[218]

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[216]Kehrer, BH and Burroughs, HC. More Minorities in Health, Menlo Park, CA, The Kaiser Forums, 1994, p. 13. While this report found that Asians were represented among these professional categories at least at parity with their representation in the population as a whole, it failed to differentiate between subgroups of Asians.

[217]Petersdorf, RG, et al. "Minorities in medicine: Past, present, and future," Academic Medicine, 65(11), 1990, pp. 663-70.

[218]Rivo, ML and Satcher, D. "Improving access to health care through physician workforce reform. Directions for the 21st century," Journal of the American Medical Association, 270(9), 1993, pp. 1074-8.

Furthermore, as the general rationale for affirmative action programs has increasingly been questioned with the change in political climate in recent years, supporters of policies directed at increasing the proportion of URMs in medical professions have been forced to develop additional arguments for continuing those policies. For example, one such rationale stated in COGME's most recent report on medical education is the position that:

> People who share similar cultural patterns, values, experiences, and problems are more likely to feel comfortable with and understand each other. Minority health care providers are more likely to be culturally sensitive to their populations and to organize the delivery system in ways that better suit the needs of that minority population.[219]

In fact, this basic position has been the rationale for patient-clinician ethnic matching strategies discussed in the previous chapter. Another justification used to defend medical school admission and recruitment policies has been the position that minority physicians are more likely to practice in underserved communities and in primary care specialties.[220] Most recent data has tended to support this assertion. Studies have generally found that URM medical school graduates are more likely to choose primary care specialties.[221] However, the most recent such study did not confirm this trend.[222] Other sources have demonstrated that URM graduates are significantly more likely to practice in underserved areas. A 1985 study by the AAMC found that higher proportions of African-American and other minority students intended to practice in

[219]COGME, Council on Graduate Medical Education: Third Report, Washington, DC, U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, 1992, p. 21.

[220]Foreman, S. "Graduate medical education: Focus for change," Academic Medicine, 65(2), 1990, pp. 77-84; Johnson, C. "Challenge for the minority physician: Gaining quality health care for the underserved," Journal of the National Medical Association, 83(7), 1991, pp. 563-8; Pinn-Wiggins, VW. "Comments from the National Medical Association concerning a "white paper" on proposed strategies for fulfilling primary care manpower needs," Journal of the National Medical Association, 82(4), 1990, pp. 245-8.

[221]Cuca, JM. "1978 U.S. medical school graduates: Career plans by racial/ethnic identity," Journal of Medical Education, 55(8), 1980, pp. 721-4; Adams, EK and Bazzoli, GJ. "Career plans of women and minority physicians: Implications for health manpower policy," Journal of the American Medical Women's Association, 41(1), 1986, pp. 17-20.

[222]Babbott, D, et al. "Racial-ethnic background and specialty choice: A study of U.S. medical school graduates in 1987," Academic Medicine, 64(10), 1989, pp. 595-9.

such areas.[223] In 1993, Kassebaum, et al. demonstrated that ethnic minority graduates were four times more likely than non-minority graduates to express an intention of practicing in socioeconomically deprived areas.[224] Aside from such justifications, arguments have also been made regarding the intangible roles played by minority physicians--for example, as advocates of their respective communities' health needs.[225]

Given the current leveling trend in the proportion of recent URM medical school graduates, a number of strategies have recently been proposed for increasing the representation of such groups in health care professions. One of the most promising such approaches has been the development of vertically integrated programs designed to recruit members of minority communities into careers in medicine. For example, the National Medical Association, the nation's leading African-American physician organization, has recently engaged in a partnership with the U.S. Public Health Service to develop minority mentoring relationships between physicians and medical students.[226] Massachusetts General Hospital has developed an innovative outreach program, providing internships for both college undergraduates and high school students from minority communities. The program also included mechanisms for promoting careers in academic medicine among minority physicians.[227]

The Public Sector--Policy and Programs:

Driven by long-standing and compelling data on the problems of health access and utilization among various minority groups, efforts consistent with current

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[223]Keith, SN. "Role of minority providers in caring for the underserved," Journal of Health Care for the Poor and Underserved, 1(1), 1990, pp. 90-5.

[224]Kassebaum, DG, Szenas, PL, and Caldwell, K. "Educational debt, specialty choices, and practice intentions of underrepresented-minority medical school graduates," Academic Medicine, 68(6), 1993, pp. 506-11.

[225]COGME, p. 22.

[226]Grady, C. "The National Medical Association/US Public Health Service National Minority Mentor Recruitment Network," Journal of the National Medical Association, 84(3), 1992, pp. 222-3.

[227]Potts, JT, Jr. "Recruitment of minority physicians into careers in internal medicine," Annals of Internal Medicine, 116(12 Pt 2), 1992, pp. 1099-102.

definitions of culturally competent care at the level of policy-making have evolved on a number of fronts in recent years. At the federal government level, some of the policy efforts which evolved in the 1970s and 1980s to address issues of disparity in health status across racial, socioeconomic, and cultural groups have already been discussed. For example, the efforts of the President's Commission on Mental Health in 1978 and the numerous block grants offered for community-based interventions by the U.S. Public Health Service's MCHS in the 1980s were briefly discussed in the previous chapter.

Other highlights of recent efforts at the federal level have included the establishment, in 1985, of a Task Force on Black and Minority Health by the U.S. Department of Health and Human Services (HHS). The report produced by the Task Force led HHS to create a standing Office of Minority Health (OMH). A study performed by the OMH in 1991, which attempted to identify the most critical elements in the planning of future health programs for minority populations through a national survey of health care providers, found that cultural sensitivity was the highest ranked characteristic overall. In addition, "cultural relativity" and "cultural training for providers" were also ranked among the top 10 (out of 100 characteristics included in the survey).[228] In 1990, HHS and the Public Health Service published the most comprehensive assessment of the nation's health in its history, Healthy People 2000: National Health Promotion and Disease Prevention Objectives. In its evaluation of the nation's health, Healthy People 2000 identified a number of "special populations," including ethnic minority groups, for which specific health and health care objectives were developed.[229]

Responses at state and local levels to policy recommendations such as Healthy People 2000 have varied. In some regions, the objectives for the health of minority

[228]Simson, SP and Wilson, LB. "Planning minority health programs to eliminate health status disparity," Evaluation and Program Planning, 14, 1991, pp. 211-19.
[229]Healthy People 2000: National Health Promotion and Disease Prevention Objectives: Full Report, With Commentary, Washington, DC, U.S. Department of Health and Human Services, Public Health Service, 1991, pp. 29-42, 594-605.

populations included in Healthy People 2000 have been embraced with considerable enthusiasm. For example, in California, the State Department of Health Services (CDHS) developed a "multiethnic health promotion agenda" model and process for implementing those objectives within four ethnic minority populations identified as the most needy in the state. In this process, four multidisciplinary task forces, subdivided into regional groups, identified the most pertinent health issues within each population included.[230] While recent policy oriented efforts such as those discussed above have been a catalyst for considerable hope among many in the minority health community, others have taken a more cautious position. For example, it has been observed that while policy recommendations may be abundant, resources for implementing them are often lacking. Herbert Nickens, former director of the OMH has noted that the allocation of funding for programs directed at accomplishing the various proposed objectives has not necessarily been forthcoming.[231] Others have concluded that the competition entailed in and bureaucratic complexities of obtaining such funding often ultimately result in its misallocation.[232]

As policy-makers have searched for existing programs which might be modified to facilitate the rapid expansion of efforts to improve health care delivery and access for cultural and ethnic minority populations, an increasingly frequent subject of their gaze has been the Medicaid system. More specifically, there has been considerable recent discussion of the role of managed health care in relationship to Medicaid. It has long been known that state-federal Medicaid programs, which were originally designed to improve health access to impoverished populations, have in general included a greatly

[230]Ward, J, Collins, G, and Walmsley, J. "A model for implementing Healthy People 2000 objectives in African-American communities in California," Ethnicity and Disease, 3(2), 1993, pp. 158-68.
[231]Nickens, HW. "Health promotion and disease prevention among minorities," Health Affairs, 9(2), 1990, pp. 133-43.
[232]Kerner, p. 371; Farel, AM, Margolis, LH, and Lofy, LJ. "The relationship between needs assessments and state strategies for meeting healthy people 2000 objectives: Lessons from the Maternal and Child Health Services Block Grant," Journal of Public Health Policy, 15(2), 1994, pp. 173-85.

disproportionate number of members from ethnic minority populations. At the same time, it has been observed that many Medicaid programs have been largely unsuccessful in accomplishing the goal of providing health coverage to underserved populations. For example, in a number of states in the deep South, less than 50% of the poor are covered by Medicaid and in Texas, only 32% of the poor receive coverage.[233] In California, whereas 10% of the state's population is eligible for Medi-Cal (California's Medicaid program), only half of those eligible actually utilize such services.[234]

Searching for means of increasing the availability of Medicaid programs for underserved populations, policy-makers in the late 1980s and early 1990s began to experiment with managed care models of Medicaid delivery (as opposed to traditional fee-for-service models). Some data existed at that time which supported the notion that financially capitated managed care models held significant promise for increasing continuity of care and satisfaction with care among Medicaid beneficiaries, particularly non-White beneficiaries.[235] Based upon such data, a number of states developed experimental Medicaid managed care programs. By 1993, 4.8 million Medicaid patients were members of managed care programs.[236] A promising aspect of some of these programs has been the opportunity to integrate aspects of culturally competent service provision on a system-wide level.

Perhaps the most prominent example of such a program is the Metropolitan Health Plan (MHP), a county-owned health maintenance organization (HMO) operating in the Minneapolis-St. Paul, Minnesota metropolitan area. The HMO is somewhat

[233]Hewitt, W, Jr. "Minority health and public policy: Developing an agenda toward the year 2000," Henry Ford Hospital Medical Journal, 38(2-3), 1990, pp. 166-72.
[234]Fay, JS and Boehm, RJ. California Almanac, 6th ed., Santa Barbara, California, Pacific Data Resources, 1993, p. 57.
[235]Temkin-Greener, H. "Medicaid families under managed care. Anticipated behavior," Medical Care, 24(8), 1986, pp. 721-32; Temkin-Greener, H and Winchell, M. "Medicaid beneficiaries under managed care: Provider choice and satisfaction," Health Services Research, 26(4), 1991, pp. 509-29.
[236]Friedman, E. "Money isn't everything. Nonfinancial barriers to access," Journal of the American Medical Association, 271(19), 1994, p. 1537.

atypical in that it developed out of a major 910-bed county medical center with strong academic linkages, which had a history of serving the poor, as well as ethnically and culturally diverse populations. In 1994, it provided services to 30 percent of the Medicaid recipients and 70 percent of the general assistance recipients in the area it served. Among Medicaid-managed care programs which have been developed, MHP has been unique in the degree to which it has embraced the goal of cultural competency and has incorporated services which have fallen under the rubric of this concept. For example, the program has offered extensive language services: it boasts that interpreter services are available in 131 languages, that bilingual staff are available in six languages, and that interpreter services are available on-site 24-hours a day. It has also integrated numerous community outreach programs into its structure, including interventions for child wellness, perinatal health, and adolescent health. Transportation provision for members with limited resources and community outreach counselors are other services offered by MHP. Of further significance is the fact that MHP was profitable every year between 1989 and 1994.[237]

Beyond the MHP example, other public sector efforts to experiment with Medicaid-managed care models have generally focused on socioeconomic variables more than cultural ones. For example, two promising models have been developed by public agencies and publicly funded corporations in Philadelphia and Harlem to provide Medicaid-managed care services to inner city populations.[238] While these programs have developed innovative community outreach and community linkage strategies, neither has included cultural competency as a primary goal.

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[237]Bluford, JW. "A public-sector HMO in a competitive market: Ensuring equity for the poor," Journal of Health Care for the Poor and Underserved, 5(3), 1994, pp. 192-8, 199-201.
[238]Goldman, B. "Improving access to the underserved through Medicaid managed care," Journal of Health Care for the Poor and Underserved, 4(3), 1993, pp. 290-8; Henley, AJ and Clifford, MC. "Managed health care for Medicaid enrollees: The Philadelphia model," Journal of Health Care for the Poor and Underserved, 4(3), 1993, pp. 210-8.

Medicaid-managed care programs have certainly not gone uncriticized. Vernellia Randall has argued that while managed care organizations are designed to reduce "unnecessary" care, through extensive utilization review and financial risk-shifting, these same mechanism may operate in direct conflict with goals of improving the health status of the underserved. One proposed reason for this is that the definition of "unnecessary" care is subject to very significant bias towards existing "European-American middle-class-based cultural norms," and is not defined by what might be culturally appropriate for a particular underserved group. Randall also points out that ethnic and cultural minority groups, who currently display underutilization rather than overutilization of health services as well as poorer health status, will likely require more services in the immediate future than the "norm."[239] Whether such troubling hypotheses will be realized is, of course, unknown. Nonetheless, given the current degree of momentum which managed care models are enjoying, answers to such questions will be obtained in the future, one way or the other.

The Private Sector--Marketing to Culture:

While there have been an increasing number of approaches proposed and developed for improving health care delivery and access for cultural minority populations at the levels of the individual health care professional, the local community agency, and now the public sector Medicaid-managed care program, it is very difficult to assess the degree to which these strategies have been implemented in the private sector. There have been no studies, academic or otherwise, which have attempted to obtain such data. The small amount of data which does exist in this area is primarily available within the mainstream health care literature oriented towards hospital administrators and other health system executives.

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[239]Randall, VR. "Impact of managed care organizations on ethnic Americans and underserved populations," Journal of Health Care for the Poor and Underserved, 5(3), 1994, pp. 224-36, 237-9.

Despite the above caveats, the questions of what degree to which cultural competency exists in the private sector of health care and in what manner it is being presented and implemented are of great significance for a number of reasons. First and foremost is the fact that the vast majority of Americans receive health care from private sources. If culturally competent care is to become available to the great number of Americans who would benefit from it, the adoption and incorporation of concepts of such care by private sector health providers is essential. Furthermore, there has been recent discussion in certain regions of potential means of extending culturally competent care into the private sector through public policy interventions. For example, in California, where Medicaid-managed care programs first appeared in the 1970s, cultural competency recommendations have recently been submitted to the State Department of Health Services.[240] In the future, some of the recommendations included in this document will likely be used as criteria for selecting private sector organizations for participation in California's Medi-Cal-Managed Care Program. Of additional significance is the fact that the application of concepts of culturally competent care in the private sector will almost certainly have a profound influence on future definitions of the concept. In fact, such influences are already beginning to become apparent and will be further discussed in this section.

Perhaps not surprisingly, with regard to issues of ethnic and cultural diversity and health care, a significant area of interest for administrators in the private sector has been that of health care financing. A 1988 study of the implications of racial and ethnic differences in health care insurance rates for private sector marketing strategies, by Kenneth Mayer and Louis Pol, summarized the underlying conflict between the interests of the public sector and the private sector:

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[240]California Cultural Competency Task Force. Recommendations for the Medi-Cal Managed Care Program, non-circulating final document, submitted to the California Department of Health Services on February 8, 1994.

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The public sector interests concern the provision of adequate health care for all members of society. The private sector issues are in regard to the maintenance of a relatively free market health insurance system that does not overly tax the copayers of insurance benefits--namely federal and state governments as well as private sector employers.

In their study, Mayer and Pol viewed the 37 million Americans then uninsured as a "large untapped market for health care coverage." Moreover, they concluded that the disproportionate number of uninsured Blacks and Hispanics (12.1 million or 33% of those uninsured)--not to mention those covered by Medicaid--represented a particularly important market which needed special targeting by the private sector. In their final discussion, Mayer and Pol suggested that:

> Because of its youth and somewhat lower level of educational achievement, much of the uncovered population will not experience a felt need for products. This complicates the marketing strategy because even though need may exist, many of the target group are unaware of the need or simply have a different set of priorities. This paradox of need may be able to be addressed through the cultural ties of the ethnic/racial group...Research must be directed toward determining the extent to which cultural ties influence the purchase patterns of lower income minority groups, especially as they relate to the buying of services which serve as protection against an event that may or may not occur.[241]

While some might find the logic of certain conclusions in this statement to be somewhat disturbing (and perhaps more than a little unenlightened), for better or for worse, the general principles which Mayer and Pol set forth have been major driving forces for the development of culture-specific strategies of health care delivery in the private sector. Furthermore, the language of generalizations which they use is fairly pervasive throughout health care management literature in this area. Take, for example, an entry that recently appeared in a mainstream journal oriented to health care executives, which might be interpreted as an attempt to dispel concerns such as those set forth in the previous statement:

> Myth Number One: Ethnic populations are not financially desirable target populations.
> The truth is that Hispanics and Asians *are* less insured than the larger population. Yet, they are willing and eager to pay their health care bills; it is an

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[241]Mayer, K and Pol, L. "Racial and ethnic differences in healthcare insurance: Implications for marketing strategies," Health Marketing Quarterly, 5(3-4), 1988, pp. 143-55.

honor and responsibility they want...Some hospitals have approached Hispanic populations by offering reduced prices and experimenting with discount coupons, but many of these programs failed. For Hispanics, health care is a dignified and respected service. Hispanics are looking for fair and equitable prices, not cheap prices. And when the health care decision involves their children, there is little concern about price.[242]

As is likely becoming apparent, any discussion of private sector efforts in the area of health care provision to cultural and ethnic minority populations cannot avoid a central underlying concept: *marketing*. While the concept of marketing health care products specifically to ethnic or cultural groups is a relatively recently conceived one,[243] the general trend of marketing to such groups is in no way a new phenomenon. For example, the intensive targeting of ethnic minorities for the marketing of alcoholic beverages, tobacco products, high cholesterol foods, and other products linked to increased risk for a number of serious health problems, has been well documented.[244] Indeed, it is not unusual for widely read business journals to include articles identifying successful strategies for marketing to minority populations. One such article which recently appeared chose to laud the efforts of the Adolph Coors Company in targeting its products on Hispanics by supporting community cook-offs and *Cinco de Mayo* events across the country.[245]

In all fairness to the administrators of private sector health care organizations, there is a vast ethical gulf separating the marketing of cigarettes and malt liquor to minority populations and the marketing of health care plans to those populations. A recent cover story in Hospitals, a widely read mainstream journal directed primarily at health care administrators, suggests that there is genuine interest in issues of cultural

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[242]Youkstetter, D and Schore, C. "Marketing to ethnic populations," Healthcare Exececutive, 3(2), 1988, p. 19.
[243]Colon, W. "Marketing to ethnic populations of growing importance," Physician Financial News, 6), 1988, pp. PB18-22.
[244]Maxwell, B and Jacobson, M. "Targeting Hispanics," Marketing Disease to Hispanics : The Selling of Alcohol, Tobacco, and Junk Foods, Washington, DC, Center for Science in the Public Interest, 1989, pp. 27-46.
[245]Livingston, S. "Marketing to the Hispanic-American community," Journal of Business Strategy, 13(2), 1992, pp. 54-7.

diversity and their relevance to health care provision within the private sector.[246] In

fact, a review of the small quantity of literature on the subject of marketing programs to

ethnic minority groups reveals some current trends which are at least partially

encouraging.

One such trend has been an apparent interest in efforts to identify and

disseminate information on the characteristics of programs which have been successful

in addressing the culture-related needs of populations served. For example, a recent

health care management journal offered a brief summary of the efforts of a free-standing,

private hospital in Florida to conduct a survey of its Hispanic population to assess the

health care needs of that population.[247] An entry in another journal geared towards

health care executives outlined some of the lessons of health care provision learned in

the development of a private HMO oriented towards a predominately Chinese-

American community in Los Angeles.[248]

Profiles in Healthcare Marketing, a mainstream journal directed at

administrators of hospitals and other health care organizations, has recently included a

series of a vignette articles highlighting a handful of regional efforts by private sector

organizations to enhance services to cultural minority populations. The approach

promoted by this series is that of *niche marketing*, a general marketing concept which

appears to currently be in vogue in the health care management community. One

example in the series summarized the modest efforts of a non-profit, community

hospital in Alaska to offer a "cultural workshop" focusing upon the specific health-

relevant cultural beliefs of three Native Alaskan groups in the area served.[249] Another

focused on the experiences of a of a neighborhood clinic in an African-American

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[246]Hagland, MM. "New waves. Hospitals struggle to meet the challenge of multiculturalism now--and in the next generation," Hospitals, 67(10), 1993, pp. 22-31.
[247]Weinstein, A. "How a south Florida hospital targeted Hispanic consumers," Health Care Strategic Management, 6(2), 1988, pp. 17-8.
[248]Youkstetter and Schore.
[249]"Niche marketing. Case history I: Understanding why Native Alaskans crave moose nose," Profiles Healthcare Marketing, 46, 1992, pp. 3-4.

community in Chicago. The clinic utilized such strategies as outreach to community leaders and local churches.[250] Yet another example highlighted the efforts of a moderately-large non-profit managed care program established by Blue Cross/Blue Shield in Pennsylvania to provide culturally sensitive services to an ethnically diverse, largely Medicaid enrollee population in Philadelphia. The availability of various language services and community outreach programs were emphasized.[251]

However, despite the optimistic picture painted by the Profiles in Healthcare Marketing series, a panacea of culturally competent care has certainly not yet been realized in efforts to market health care to minority communities. For example, an article in the late 1980s which appeared in Hospitals identified eight important rules of marketing to minorities, which are fairly representative of the shift in philosophy which the private sector is introducing:

- Don't think that hiring and promoting minority employees is the end-all in attracting minority groups.
- Clearly target an ethnic population. Know your area's demographics, and target only one group at a time.
- Health care is a family decision in many cultures, so market to the entire family, not just to one family member.
- Overcome language barriers. Use international signs and hire foreign-speaking [sic] employees to provide general information and answer questions on such subjects as claims and billing and policies and procedures.
- It's not necessary to have foreign-speaking physicians, but physicians should familiarize themselves with some words of the community's language and with certain aspects of the culture, such as major holidays.
- Work through the community network when promoting to an ethnic population. This means working closely with community agencies and organizations.
- Advertise in local community newspapers. But remember to first check to see what the local newspaper ads look like. The, don't try to outdo the other ads.
- One last "inexpensive" tip: Place an ad in the ethnic community's yellow pages.[252]

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[250] "Niche marketing. Case history II: A Chicago clinic becomes African-American community's new neighbor," Profiles in Healthcare Marketing, 46, 1992, pp. 5-7.
[251] "Streetwise managed care. Six hospitals collaborate to improve access and healthcare for Medicaid patients. Health Partners of Philadelphia," Profiles in Healthcare Marketing, 59, 1994, pp. 2-7.
[252] Martinsons, JN. "What to consider when marketing to minorities," Hospitals, 62(12), 1988, p. 44.

Indeed, there have been more than a few demonstrations of private sector approaches which are somewhat less than flattering to the concept of culturally competent health care. For example, one program highlighted in the Profiles in Healthcare Marketing series was a clinic specializing in issues of male erectile dysfunction within a predominately Hispanic community.[253] Another example discussed the efforts of a free-standing private hospital in Florida to market its services to a growing Hispanic community through the use of an extensive advertising campaign and by enlisting a public relations firm from the Latino community. One of the aspects of this program touted was the fact that, "Changes to the menu have made the hospital feel more like home for Hispanic patients. The hospital now offers Spanish fare such as black beans and rice, fried plantains, and flan."[254] While offering culturally distinctive food would likely be considered a minor priority in the development of culturally competent programs to many, it seems that there may be somewhat of a preoccupation with the gastronomic aspects of culture in some health care administration circles. In a separate article, a hospital administrator was quoted as being somewhat baffled as to why this intervention was not successful: "I don't understand why we're not attracting the Hispanic community; we serve Mexican food in the cafeteria."[255] Another source quotes an administrator at a prominent New York hospital, who proudly stated that, "We offer the Spanish patients *arroz con pollo*, and the Chinese patients steamed fish with teriyaki."[256] (The reader will please note that teriyaki is a distinctively Japanese dish).

All humor aside, there are valuable lessons to be learned from the above examples. Perhaps the most obvious piece of information which is evident from the

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[253]Early, P. "Cultural marketing. Centro de Impotencia targets Hispanic males," Profiles in Healthcare Marketing, 42, 1991, pp. 12-5.
[254]"Niche marketing. Case history III: One hospital, two cultures in Hispanic Miami," Profiles in Healthcare Marketing, 46, 1992, pp. 8-9.
[255]Youkstetter and Schore, p. 20.
[256]Sherer, J. "Crossing cultures: Hospitals begin breaking down the barriers to care," Hospitals, 67(10), 1993, p. 31.

preceding discussion is that there is very little data which exists regarding the penetration of culturally competent practices into the private sector. The few examples which have been highlighted by health care marketing journals can hardly be considered representative of the full range of health care organization structures and policies. Nonetheless, even among the few examples discussed, it is obvious that there is broad variation in the specific approaches which have been undertaken in the private sector. While this is perhaps not a surprising observation, it will be critical to understand the extent of such variation if future policies are to be developed in an appropriate manner. The variation which exists from organization to organization points to another significant trend. As haphazard as the process may seem, organizations in the private sector are experimenting with new approaches to providing health care services to culturally diverse populations. Culture is increasingly being viewed as an entity which can not only be marketed to, but commoditized as well. As this process continues, the priorities and definitions of culturally competent care will almost certainly be modified.

The transition from an understanding of cultural competency as an academically synthesized construct towards an appreciation that cultural competency might be used as a marketable resource represents the greatest challenge which currently faces efforts to utilize this concept as a vehicle for improving the health status of ethnic and cultural minority populations. In certain respects, it would seem that the gulf separating those definitions of culturally competent care developed in the first two chapters of this paper from principles of "marketing to culture" discussed in this last section is unbridgeable. If this is indeed to be the case, it is a reflection of the unfortunate political and philosophical barriers that now separate academia, the public sector, and the private sector. Failure would be a reflection of both the private health care administrator's distaste for all things promoted exclusively in the name of social justice, and the academician's revulsion at all things done in the name of the bottom line. If it is not to be the case, there will clearly have to be significant channels of communication created

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between the diversity of players currently involved in efforts to provide health care to underserved cultural and ethnic minority populations.

In fact, there are valid reasons to believe that cooperative efforts can emerge-- even among such seemingly strange bedfellows. In 1981, Katherine Alexander and James McCullough published a study of the application of marketing research and targeting principles in the development of an intervention to increase rates of Pap test screening in a low-income, underserved Mexican-American population. They found that incorporation of marketing strategies resulted in an intervention which significantly reduced cultural barriers to participation and insured adequate screening in this population.[257] Since Alexander and McCullough published their results, a considerable number of public health programs have either explicitly or implicitly utilized mainstream marketing strategies to better accomplish their goals. Coming from a private sector perspective, Steve Rabin has recently explored the development of a new paradigm for understanding concepts of race, ethnicity, and culture within the context of health care marketing. Rabin investigates the pitfalls of ethnic stereotyping, what he refers to as the "fallacies of cultural labeling." In challenging the stereotyping of ethnicity and culture-- the traditional standby of private sector efforts to market to minority groups--Rabin provides a springboard for future efforts to market health care programs to diverse segments of the population.[258]

In addition to the above trends, there are other reasons for optimism regarding the future development of private sector approaches to cultural diversity and health care provision. While this section has emphasized the principle of *marketing to culture* as a unifying theme in the growing literature emerging from the private sector, another concept which is beginning to emerge is that of *managing culture* as a valuable resource

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[257]Alexander, K and McCullough, J. "Application of marketing principles to improve participation in public health program," Journal of Community Health, 6(3), 1981, pp. 216-22.
[258]Rabin, SA. "A private sector view of health, surveillance, and communities of color," Public Health Reports, 109(1), 1994, pp. 42-5.

for health care provision. For example, a recent article in <u>Hospital and Health Services Administration</u> provides a model for utilizing the cultural and ethnic diversity of clinical employees within a health care organization as a competitive resource for providing health services to culturally diverse populations.[259] While such thinking may presently be near the periphery of discussions of marketing health care to culturally diverse populations, the notion that cultural diversity could in fact provide organizations with competitive advantages in the marketplace seems to be one which players from both the private sector and the academic sphere could adhere to.

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[259]Muller, HJ and Haase, BE. "Managing diversity in health services organizations," <u>Hospital and Health Services Administration</u>, 39(4), 1994, pp. 415-34.

Chapter 4: Managing Care Across Cultures--
A Survey of California's Managed Care Organizations

Background--The California Crisis:

In California, the problem of inadequate access to health care among ethnic and cultural minority populations is both acute and severe. The total proportion of California's population comprised by racial and ethnic minorities is among the highest of any state in the nation: currently, California's ethnic minority composition is 26% Hispanic, 9% Asian, 7% African-American, and 1% Native American and other minority groups.[260] Although Whites still comprise a slight majority, making up 57% of the state's population, Hispanic and Asian minority groups are the most rapidly growing segments of the state's population. Projections estimate that by the year 2000, Whites will comprise only 51% of the state's population, with Hispanics and Asians making up 29% and 13% respectively.[261] It has been further projected that by the year 2010, Whites will no longer constitute a majority group, at 46% of California's population, and that the state's non-White Hispanic population will reach parity with its White population by the year 2020 (at 41% of the total population for each group).[262]

Furthermore, much of the current rate of population increase for the most rapidly growing minority groups is due to accelerating rates of immigration from other countries. In 1990 California received 44% of the total number of immigrants to the United States (including 39% of immigrants from Asian countries, 62% of those from Mexico, 58% of those from Central American countries, and 48% of those from Eastern Europe and the

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[260]U.S. Bureau of the Census, Statistical Abstracts of the United States: 1992, 112th ed., Washington, DC, pp. 24-25.
[261]California Systems Capacity Task Force, Now or Never: Ensuring Primary Health Care in California, Berkeley, CA, The Children & Youth Policy Project, 1993, p. 26. These figures are from 1990 U.S. Census figures which do not account for undocumented aliens who are members of minority groups.
[262]Fay and Boehm, p. 3. These figures are based upon estimates from the California Department of Finance, Population Research Unit.

former Soviet Union).[263] In 1990 it was also reported that 21.7% of California's population was foreign born.[264] Furthermore, between 1986 and 1987, California received 46% of the total number of refugees to the United States. The groups most highly represented among these recent refugee immigrants were Southeast Asians (primarily Cambodians and Hmong), Middle Easterners (such as Afghans and Iranians), Africans (particularly Ethiopians), and Eastern Europeans.[265] The significance of differences in cultural perceptions of health care are considered especially pronounced among recently immigrated groups--who are less acculturated and inherently have poorer access to health care resources.[266] This inadequate access to health care is only worsened by the additional financial and psychosocial problems common among recent immigrants, particularly among refugee populations.

Somewhat related to the issue of immigration is the high prevalence in California of households in which English is never spoken or rarely spoken. According to the 1990 U.S. Census, at least 1.6 million Californians (5.5% of the state's population) live in households which are "linguistically isolated" (defined by no one in the household over the age of thirteen years being an English speaker).[267] It was also reported that 31.5 % of the population lives in households in which English was not the primary language spoken.[268] As has been discussed earlier in this paper, linguistic barriers have been frequently shown to contribute to inadequate utilization and access to health services.

While ethnic minority groups are often subject to inadequate health access as a result of factors which fit into a more traditional definition of culture, they are often also

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[263]U.S. Bureau of the Census, Statistical Abstracts of the United States: 1992, 112th ed., Washington, DC, p. 12.
[264]U.S. Bureau of the Census, Statistical Abstracts of the United States: 1994, 114th ed., Washington, DC, p. 54.
[265]Barker, JC. "Cultural diversity--changing the context of medical practice," Western Journal of Medicine, 157(3), 1992, pp. 248-54. Again, these observations do not include rates of immigration for undocumented people.
[266]Barker, p. 252.
[267]California Systems Capacity Task Force, p. 26.
[268]U.S. Bureau of the Census, Statistical Abstracts of the United States: 1994, 114th ed., Washington, DC, p. 54.

underserved for reasons which are based primarily on socioeconomics. This is true not only for groups which have recently immigrated to California from other countries, but for well established groups as well. An often cited example is the fact that in California, the infant mortality rate for African-Americans is nearly twice that of Whites (15.9 per 1,000 births vs. 8.2 per 1,000 births).[269] Another indicator of the negative impact of socioeconomic factors on health access for minority groups is the high rate of health uninsurance among these groups in California. In 1986, while 15.1% of California's White population was uninsured, the figures were much higher for all other groups: 37.1% for Latinos, 25.2% for African-Americans, and 19.9% for Asians and others.[270]

With California's population rapidly becoming more ethnically and culturally diverse, the great variation in health care needs of specific minority groups is becoming increasingly apparent. The California Systems Capacity Task Force, a privately funded public interest research group, recently performed a major needs assessment of the state's health care system. The resulting study found: 1) a close association between maldistribution of health care resources and geographic, socioeconomic, and ethnic variables; 2) that cultural and language barriers represented a significant obstacle to health care access for particular ethnic populations; and 3) that there was a great need for resources and guidelines to improve and coordinate services for women and children with diverse health care needs. Furthermore, it also acknowledged that there were critical gaps in data on providers, particularly with regard to issues of ethnicity and culture and the ability to provide services to underserved populations.[271]

In certain respects, California has been a leader in the development of interventions designed specifically to improve the health of multicultural populations. Many of the projects and programs discussed in the previous chapters of this paper

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[269]U.S. Bureau of the Census, Statistical Abstracts of the United States: 1992, 112th ed., Washington, DC, p. 81.

[270]Fay, JS and Boehm, RJ. California Almanac, 4th ed., Santa Barbara, California, Pacific Data Resources, 1990, p. 57.

[271]California Systems Capacity Task Force, pp. 8, 27, 32,48, 58.

were, in fact, developed within communities in California. Nonetheless, there is almost no data on the degree to which these largely academic and locally developed interventions have been incorporated into the health care system in a broad context. To date, there have been no large scale attempts to assess the prevalence of these policies, practices, and structures among health care provider organizations. This is due in part to the fact that there is currently only one published index which exists for measuring cultural competency at an organizational level.[272] Furthermore, there have been no efforts which have attempted to assess the likely response to legislative and/or policy interventions directed at increasing culturally competent policies, practices, and structures among health care providers. For example, there has been no study which has attempted to assess perceptions among a broad range of policy-makers and health care administrators regarding: 1) the perceived necessity of interventions, legislative or otherwise, to increase cultural competency in the health care system; 2) the degree to which the language of culturally competent health care has penetrated into the health care system at an administrative level; and 3) the perceived long term cost-effectiveness of efforts to increase levels of cultural competency on a system-wide level.

With California currently leading the rest of the nation in the transition to managed care health systems, it was felt that a study of cultural competency among California's managed care organizations would be particularly valuable. In recent years, California has consistently ranked first in the nation in the proportion of its population receiving care from managed care organizations. In 1990, 31.4% of the state's population was enrolled in health maintenance organizations (HMOs, the most common category of managed care organization types).[273] In 1991, the ten largest HMOs provided health care to 26% of the state's population.[274]

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[272]Dana, et al. "A checklist for the examination of cultural competence in social service agencies."
[273]The Universal Healthcare Almanac, Phoenix, Arizona, Silver & Cherner, 1990, p. 91-1.
[274]Fay, JS and Boehm, RJ. California Almanac, 6th ed., Santa Barbara, California, Pacific Data Resources, 1993, p. 28. These figures are from the Group Health Association of America.

Goals of the Project:

The primary goal of the project *Managing Care Across Cultures* was to provide descriptive data assessing the prevalence of culturally competent policies, practices, and structures among managed care organizations in California. While there has been much recent discussion regarding the importance of cultural competency among health care providers as it relates to the serious problem of health care access among California's underserved populations, there has been no study to date which has attempted to gauge the prevalence of culturally competent health care practices in California. Furthermore, there has been no survey of how health care provider institutions might respond to legislative guidelines for cultural competency which are currently being considered.

Because there was no intervention or established correlation being examined, the study was intended to be exploratory and cross-sectional in nature. However, it was also intended that the study have the potential to be extended into a longitudinal study, should a legislative intervention be implemented in the future. Beyond obtaining descriptive data on the prevalence of culturally competent policies and practices, other specific goals of the survey included the following:

1) To objectively assess the degree to which managed care organizations are culturally competent at an institutional level. Means for assessing this would include the development of an administrative level cultural competency index.

2) To obtain data on variables which may be correlated with institution level cultural competency, such as organization classification (HMO, PPO, etc.), organization size, geographic localization of membership, representation of primary care specialties among employed physicians, etc.

3) To assess perceptions among managed care administrators regarding currently proposed legislative guidelines for improving cultural competency at the level of the health care organization.

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The study was conducted in direct cooperation with a legislative/research group, with the underlying goal of providing this group with baseline data on the prevalence of policies, structures, and practices associated with the concept of culturally competent health care. This group, the Cultural Competency Task Force (CCTF), is an ad hoc statewide body which was established by the Children and Youth Policy Project (CYPP), a standing legislative/research group within the Institute for the Study of Social Change at the University of California at Berkeley. The CCTF consists of a core of CYPP staff which is advised by a body of academic researchers, policy-makers, community organizers, clinical health professionals, health care administrators, and government employees who have expert knowledge of and/or experience with the provision of health services to culturally diverse and underserved populations. The CCTF was created in partnership with the California Department of Health Services (CDHS) to facilitate the development of culturally competent health care services in California, in order to improve access to quality care for children, youth, and families within the state. It was established with a primary goal of developing definitions and quantifiable guidelines for the delivery of culturally competent health care services. Additional goals of the CCTF include the development of recommendations for implementing these guidelines and the identification of incentives which will encourage the implementation of those guidelines.

Methodology:

- *Instrument Development:*

With the exception of a "checklist" for assessing culturally competent structures and practices within social service agencies which was developed and evaluated by Richard Dana and colleagues in Portland, Oregon in 1992,[275] there have been no efforts to design instruments for measuring cultural competency at the level of the health care

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[275]Dana, et al. "A checklist for the examination of cultural competence in social service agencies."

provider organization. Moreover, as has been discussed extensively in the earlier sections of this paper, comprehensive and consistently utilized definitions of such practices have not yet been established. Therefore, the first task in developing an instrument for assessing culturally competent policies, practices, and structures within managed care organizations was the establishment and validation of criteria to be utilized in measuring the concept.

Validity of criteria included in the instrument was obtained primarily by relying upon the definitions of culturally competent care developed by the CCTF. Working definitions of managed care organization level cultural competency and its specific criteria were obtained by the CCTF through: 1) an extensive health care literature review of sources utilizing the language of cultural competency, sensitivity, appropriateness, etc. and 2) a formalized process by which members of the task force conferred with one another, as well as with members of an advisory/oversight work group, to develop consensus on general definitions and specific criteria (this process included the utilization of ad hoc subcommittees, focus groups, and other informal mechanisms). Given this rigorous process of criteria selection, it was concluded that broad content validity was established regarding the definitions and specific criteria which the CCTF ultimately presented.

The criteria for cultural competency which were produced by the CCTF were subsequently organized into quantifiable guidelines, which took final form in a formal document entitled "Recommendations for the Medi-Cal Managed Care Program."[276] This document was submitted to the CDHS in February of 1994. The guidelines were organized into seven areas of service delivery: 1) community linkages, 2) demographic description of geographic service area, 3) capacity of applicant plan, 4) spectrum of need, 5) service elements, 6) recommended role for CDHS, and 7) quality assurance and

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[276]California Cultural Competency Task Force. Recommendations for the Medi-Cal Managed Care Program, non-circulating final document, submitted to the California Department of Health Services on February 8, 1994.

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monitoring. Under each of these general areas, specific criteria and recommendations were provided.

The development of the survey instrument utilized in the *Managing Care Across Cultures* project essentially represents an operationalization of the guidelines established by the CCTF into a self-administered questionnaire format. While it was impossible to incorporate all of the CCTF criteria into the instrument, every effort was made to include components representative of each area of service delivery presented in the CCTF's final recommendations. All of the components included in the instrument were found to be consistent with definitions of culturally competent care discussed in earlier sections of this paper as well as with the criteria utilized by Dana, et al. in their "Agency Cultural Competence Checklist."[277]

The questionnaire utilized in the survey was developed using the methodologies developed by Aday and Converse and Presser.[278] In its final format, it was composed of two sections of closed-ended questions: the first obtaining objective data--ordinal and interval whenever possible--relating to the structures, policies, and practices of managed care organizations; the second consisting of attitudinal and knowledge level questions. The specific components of the questionnaire are discussed below.

- *Pre-Testing:*

The finalized questionnaire was pilot tested with respect to: 1) general readability and design and 2) specific content and applicability. The former was performed by pre-testing with faculty and students in the University of California, Berkeley-San Francisco Joint Medical Program (UCB-UCSF JMP), with University of California public health students in a survey questionnaire design course, and with survey design experts at the Survey Research Center at the University of California. The

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[277]Dana, et al. "A checklist for the examination of cultural competence in social service agencies."

[278]Aday, LH. Designing and Conducting Health Surveys, San Francisco, Jossey-Bass Publishers, 1989; Converse, JM and Presser, S. Survey Questions: Handcrafting the Standardized Questionnaire, Newbury Park, Sage University Press, 1986.

latter was accomplished by submitting the questionnaire for critical review by approximately 10 members of the CCTF's core "work group" and a small sample of 3 high level administrators in one of California's private, non-profit health maintenance organizations.

- *Survey Administration:*
  - *Sample frame:*

    The frame consisted of highest level administrators (CEOs, presidents, or their equivalents) of California's health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other managed care organizations. The listing used in obtaining the working sample frame was the 1994 HMO/PPO Directory from Medical Device Register.[279]

  - *Sampling methodology:*

    Because of the relatively small size of the sample frame, it was possible to administer the survey to administrators in all of the California managed care organizations listed. Of the approximately 130 managed care organizations listed by Medical Device Register as operating in California, 93 were ultimately included in the sample. The remaining organizations were excluded from the survey based upon one or more of the following criteria: 1) the services provided by the organization were exclusively dental or optical; 2) it was concluded that the organization was no longer in operation (for example, if telephone and mail correspondence yielded no response or valid forwarding information); 3) the organization was in the process of ceasing to provide services (for example, due to bankruptcy or to an imminent merger with another organization); 4) the organization was a regional division or other non-autonomous subsidiary of a larger organization that was already included in the survey; 5) the highest

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[279]Medical Devices Register, HMO/PPO Directory: 1994 U.S. Managed Health Care Organizations in Detail Plus Key Decision Makers, Medical Economics Data, 1993, pp. I-14-I-40.

administrative body of the organization was located outside of California, and no division of the organization existed to separately administer services offered in California.

- *Human subjects approval:*

A proposal was submitted to the Committee for Protection of Human Subjects (CPHS) at the University of California at Berkeley in April of 1994. The proposal was reviewed and approved by the CPHS on May 13, 1994 (project #94-5-41). A copy of this approval is available as *Appendix A.*

- *Questionnaire:*

Samples of the questionnaire, cover letter, and consent form utilized are available as *Appendix B.* The survey instrument consisted of a self-administered mail questionnaire requiring roughly 30 to 45 minutes to complete. The first mailing took place in mid-December, 1994. Three mailings were made at approximately 3 week and 6 week intervals from the date of the first mailing. Following the third mailing, telephone contact was made with non-responding organizations. No material incentive was provided, although summary results were offered to participants through a check-off form.

The questionnaire was composed of two sections. The first section obtained objective information regarding organization structure, practices, and policies. Data was obtained through closed-ended questions (of the "check box" and "circle answer" nature). The second section obtained information relating to knowledge levels, perceptions, and opinions among organization administrators, which dealt with issues of health care provision to culturally diverse populations. Again, this was accomplished through closed-ended questions. The specific information obtained in the questionnaire included the following:

Section I:

- Organization demographics:
    - Organization size by membership *(quasi-ordinal ranges)*

- Organization size by hospitals operated *(interval)*
- Managed care organization type--HMO, PPO, etc. *(nominal)*
- For profit status *(nominal)*
- Relationship between organization and associated primary care physicians *(nominal)*
- Geographical localization of organization membership *(interval)*
- Representation of primary care specialties among associated physicians *(ordinal)*
- Ethnic composition of organization personnel (physicians, non-physician clinicians, non-clinical staff), board, and membership *(interval)*
- Percentage of members receiving Medi-Cal *(ordinal)*
- Proportion of non-English speaking (NES) and non-English proficient (NEP) members *(ordinal)*

- Nominal data on the availability and reliability within the organization of information of the following types:
    - Ethnic composition of organization personnel and membership
    - Proportion of bilingual and multilingual personnel
    - Proportion NES and NEP members
    - Demographics of the general population in the geographical service area of the organization:
        - Ethnic composition
        - Education levels
        - Number of NES/NEP households
        - Percentage receiving AFDC
        - Percentage Medi-Cal eligibles, enrollees, and users
        - Gender and age breakdown of Medi-Cal eligibles

- Quasi-ordinal data on the proportion of the organization's clinical sites engaging in the following practices which have been included within the definition of culturally competent health care:
    - Linkages with community organizations of five types:
        - Subcontractual
        - Planning and policy partnerships
        - Community organizations/individuals serving in a formal advisory capacity
        - Formal arrangements for providing referrals to community organizations
        - Community organizations/individuals participate in evaluation of the managed care organization.
    - Translator and/or interpreter services in Spanish, Chinese dialects, other Southeast-Asian languages, "other" languages not specified
    - Forms and other written materials available in non-English languages
    - Indigenous health systems/healers utilized or allied
    - Mechanisms for time flexibility and increased time allocation for culturally varied populations
    - Travel accommodations for NES/NEP patients
    - Provision of cultural sensitivity courses/training programs for clinicians
    - Procedures for responding specifically to culture-related grievances
    - Culture brokers and/or lay health advisors utilized
    - Patient-clinician culture matching strategies utilized

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Section II: The following questions were included in a closed-ended format.

- To what extent have you found cultural factors among minority populations to be significant barriers to access to health care?
- How much of a priority is it for health care provider organizations to engage in efforts which will improve access to health care for culturally different populations?
- How well equipped do you feel your organization is to provide services for a culturally and ethnically diverse population?
- In your practice as a health care administrator, how frequently have you heard the term *cultural competency* utilized?
- How confident are you in your knowledge of what cultural competency is, *in general*?
- How confident are you that you know *what specific factors contribute to* cultural competency at an administrative/organizational level?
- How desirable is the goal of health care organizations becoming more culturally competent?
- How necessary do you feel it is for managed care organizations and other health care providers to be *required* to take measures to make their practices more culturally competent?
- How cost effective do you feel efforts to increase cultural competency among provider institutions will be for those organizations in the long term?
- How satisfied are you with the amount of information that has been provided to health care administrators by the State and/or other public institutions regarding the definition of cultural competency, and what factors contribute to an organization being and becoming culturally competent?

- *Data Entry and Analysis:*

Data was analyzed using the program JMP In®, a Macintosh® compatible statistical visualization and analysis software package developed by the SAS® Institute, Inc. (Cary, North Carolina).

Analysis Plan:

The primary goal of the project was to provide cross-sectional, descriptive data on the current capacity of managed care organizations to provide services in a culturally competent manner. Hence, the primary goal of data analysis was to tabulate and summarize data--particularly data relating to the prevalence of policies, practices, and structures which have been included in the CCTF definition of culturally competent care. In addition to describing these results, an additional goal of the analysis was to tabulate the results of the section of the survey obtaining information on the knowledge levels,

perceptions, and opinions of health care administrators regarding the provision of health care to culturally varied populations.

Another goal of the analysis was to develop an index or set of indices which would provide an indication of the cultural competency capacities of organizations. Specific capacities to be measured included: 1) the capacity of the organization to numerically describe the ethnic and socioeconomic composition of its membership, its health provider employees, and the general population of its service area; 2) the capacity of the organization to reflect, in its personnel, the ethnic and linguistic composition of its membership; 3) the extent to which the organization has engaged in formal linkages with community organizations; 4) the extent to which service provision has been facilitated for non-English speaking patients; and 5) the extent to which the organization has provided other services which have been included in various definitions of organization level culturally competent care. If sufficient statistical power was obtained, the approach to be utilized in developing an index or set of indices of cultural competency capacity would include principal components factor analysis of those variables considered to be associated with each of the above capacities.

An additional aspect of the data analysis plan was to perform non-parametric bivariate studies to explore possible relationships between organization demographic variables (independent variables) and the capacities of organizations to provide culturally competent services (dependent variables). Given that much of the survey data was categorical, it was concluded that chi-square analysis would be the most robust approach to accomplishing this end.

Results and Analysis:

Respondent vs. non-respondent group comparison:

Of the 93 organizations/administrators surveyed, 35 returned the survey before the final questionnaire response deadline of January 31, 1995, yielding a response rate of 38%. This rate of response is obviously somewhat disappointing, and raises a number

of critical issues regarding the interpretation of data. Before discussing the actual results of the survey, further discussion of some of these issues is warranted.

The most significant issue raised by the relatively low rate of response is that of generalizability of results. Clearly, with a response rate of only slightly more than one-third, it would be imprudent to over-extrapolate the results of the survey to the entire population of managed care organizations in California, as the likelihood of significant response bias is very high. While it is impossible to eliminate respondent group bias from the results, it was nonetheless feasible to perform a partial analysis of the non-respondent population to ascertain possible sources of such bias. Utilizing data from two sources, 1) the 1994 HMO/PPO Directory used to obtain the sample population[280] and 2) a recent survey of 70 of California's managed care organizations conducted by a regional medical news monthly,[281] partial information on 43 out of the 58 organizations not responding (74%) was available. Data available from these sources included that for three variables: 1) size of organization in terms of membership, 2) for profit/non-profit status, and 3) percentage representation of physicians employed in primary care specialties. No attempt was made to classify non-responding organizations by health plan type (e.g. HMO vs. PPO, etc.) as inconsistency in internal structure from one organization to another made such classification impossible (for example, many organizations administered multiple health plan types).

Tables 1A-1C and *Figures 1A-1C* provide summary data comparing responding organizations to non-responding organizations with respect to the three variables for which data was available. Data for responding organizations reflects information which was self-reported in completed questionnaires. The following trends appear to be true with respect to respondents and non-respondents.

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[280]Medical Device Register.
[281]"1995 California Managed Care Survey," Northern California Medicine, Oakland, December, 1994, pp. MC-11-18.

Firstly, there was a greater representation of smaller organizations among the responding population than the non-responding population (see *Table 1A* and *Figure 1A*). Organizations with enrollment of less than 150,000 members comprised 60% of the responding population and 50% of the non-responding population. However, there was nearly identical representation of very large organizations (greater than 500,000 members) in both groups (29% and 25% for responding and non-responding, respectively).

Table 1A: Respondents vs. Non-Respondents: Organization Size

Membership size:		<10,000	10,000-49,999	50,000-149,999	150,000-499,999	≥500,000	Total
Non-respondents	*n*	5	6	8	9	9	37
	%	14%	16%	22%	24%	24%	100%
Respondents	*n*	6	6	9	4	10	35
	%	17%	17%	26%	11%	29%	100%

Figure 1A: Respondents vs. Non-Respondents: Organization Size
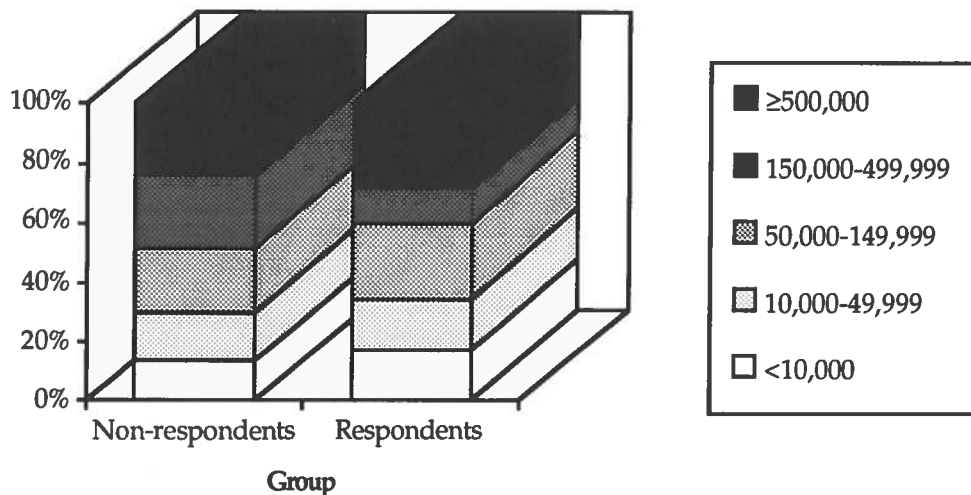
Secondly, there was a slightly greater representation of non-profit organizations among the responding group than the non-responding group (see *Table 1B* and *Figure 1B*). Non-profit organizations comprised 40% of the responding population whereas they comprised 34% of the non-responding population. Nonetheless, both of these results are consistent with figures from a recent survey of 36 of California HMOs, which

found that 36% of these organizations were non-profit (a figure of 34% of HMOs in the United States as a whole was also cited in this study).[282]

Table 1B: Respondents vs. Non-Respondents: For Profit/Non-Profit Status

| Status:		For profit	Non-profit	Total
Non-respondents	n	27	15	42
	%	64%	36%	100%
Respondents	n	21	14	35
	%	60%	40%	100%

Figure 1B: Respondents vs. Non-Respondents: For Profit/Non-Profit Status
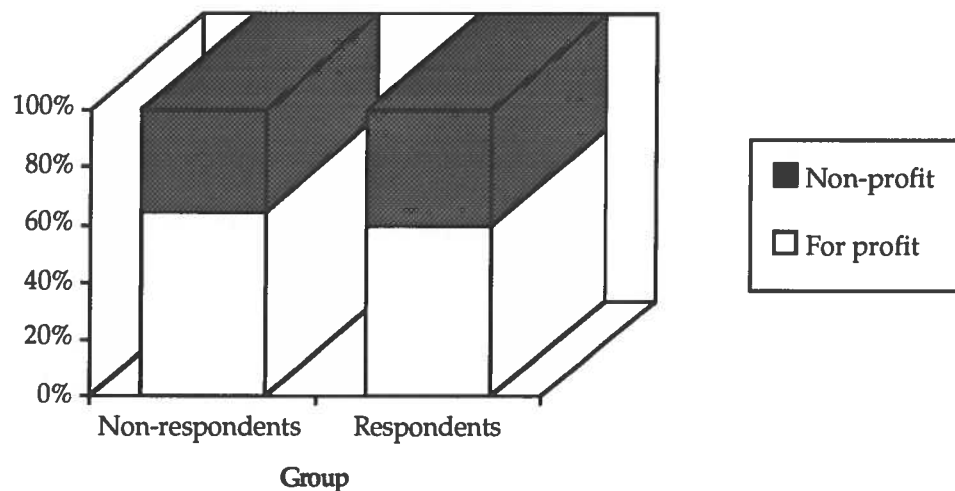
Thirdly, there was a greater representation of organizations with a high proportion of physicians employed in primary care specialties in the responding group relative to the non-responding group (see *Table 1C* and *Figure 1C*). 17% of organizations in the responding population stated that they employed 60% or more physicians in primary care specialties, whereas none of the non-responding organizations were reported to have employed percentages of primary care physicians in this range. While this difference may represent a significant bias, it should also be considered that it may be a reflection of incompatibilities in definitions of primary care specialties which were utilized by the various sources of data.

[282]1993 Profile: California Health Maintenance Organizations, Sacramento, California, California Association of Health Maintenance Organizations (CAHMO), 1993, p. 54. Note that these figures reflect only HMOs and not PPOs and other managed care organization types.

Table 1C: Respondents vs. Non-Respondents: Percent Primary Care Physicians

% Primary care physicians:		<20%	20-39%	40-59%	60-79%	≥80%	Total
Non-respondents	n	2	18	8	0	0	28
	%	7%	64%	29%	0%	0%	100%
Respondents	n	3	15	6	2	3	29
	%	10%	52%	21%	7%	10%	100%

Figure 1C: Respondents vs. Non-Respondents: Percent Primary Care Physicians
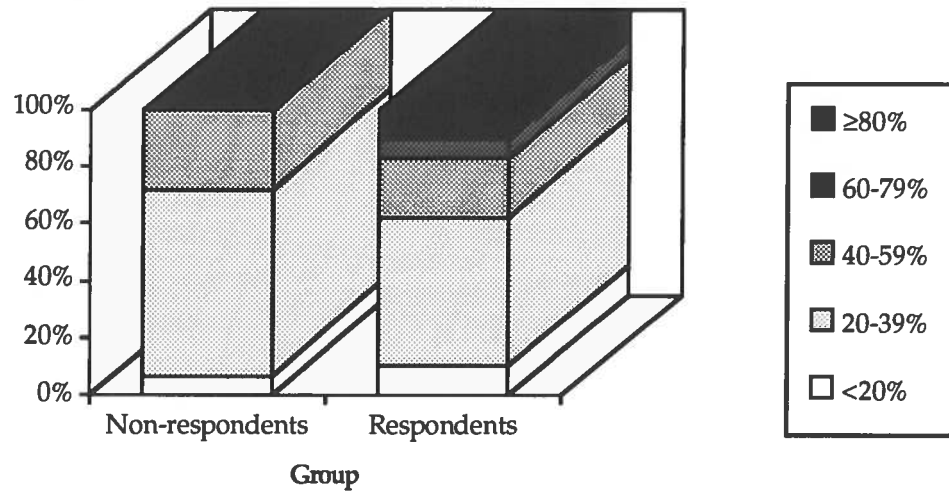
A number of the organizations which did not respond to the survey did offer specific reasons (either verbally or in writing) for not participating in the survey. The four most common reasons given by administrators for not participating were: 1) lack of time or resource availability for completing the survey, 2) a statement to the effect that the survey "did not apply" to the particular organization being surveyed, 3) lack of adequate data to complete the objective portion of the survey, and 4) failure to meet the final deadline of January 31, 1995. Of most concern with respect to possible bias in the population responding is the second reason given. While it is difficult to assess exactly which categories of organizations were most likely to indicate that the survey "did not apply," a number of administrators providing this explanation characterized their organizations as "service brokers." Such organizations indicated that they had little or no contact with clinical institutions per se, and tended to function primarily as financial administrators of health provision.

<u>*Descriptive data*</u>:

Having considered and acknowledged the above caveats relating to potential sources of response group bias, it is now possible to proceed with a discussion of the descriptive results of the survey in more detail. The discussion will begin by noting the distribution of structural characteristics of organizations which responded (i.e. the independent variables of the study) and will then move on to those variables associated with the various capacities for culturally competent care discussed above (the dependent variables).

• *Organization size:*

The distribution of organization size vis-à-vis membership size was discussed in the previous section comparing the non-respondent group to the respondent group. *Table 1A* and *Figure 1A* display the distribution of membership size of responding organizations. The distribution is based upon five ranges of magnitude. These ranges were established in the design of the study through an analysis of existing data, which suggested that the broad range of managed care organization size would distribute relatively evenly between these arbitrary categories. In fact, the distribution of organizations that responded is very well-balanced, with 34% of organizations identifying their membership size within the two smaller size ranges (less than 10,000 members and 10,000 to 49,999 members) and 40% of organizations classifying themselves into the two larger categories (150,000 to 499,999 members and 500,000 or more members). Very large organizations, of 500,000 or more members, constituted the largest single range group, with 10 organizations (29%) classifying themselves as such.

Although the number of hospitals operated by each organization was obtained as a second marker of organization magnitude, this variable proved to be unreliable and to have little descriptive value. The reason for this is that the majority of organizations responding, 25 out of 35 (71%), reported that they did not operate any hospitals at all. Furthermore, for the remaining 10 organizations, there was no discernible correlation

between organization membership size and the number of hospitals operated. For example, while one might expect organizations with a small membership to operate only 1 hospital, this proved not to be the case. Only 3 organizations reported operating a single hospital, and 2 of these were organizations with 150,000 or more members. As it turns out, these results are consistent with data obtained by a 1992 survey of 36 California's HMOs, which found that 29 of them contracted with independent hospitals and did not operate their own facilities.[283] In retrospect, the decision to include the question which asked for the number of hospitals operated was a poor one.

- *Organization structural classification:*

Self-classification of organizations with respect to structural sub-category proved to be a somewhat problematic issue, and reflects the diversity of administrative formats between managed care organizations. Six categories for structural classification were offered: 1) *group/staff model health maintenance organization (HMO)*, 2) *independent practitioner association (IPA) model HMO*, 3) *other HMO type*, 4) *preferred provider organization (PPO)*, 5) *mixed HMO/PPO*, and 6) an alternative *"other"* classification to be specified by the respondent. These categories were developed through consultation with a researcher specializing in managed care policy at the Institute for Health Policy Studies (IHPS) of the University of California at San Francisco, and were felt to be comprehensive. While most organizations classified themselves into one of the first five categories offered, 4 of them either self-classified into more than one category or apparently misclassified themselves into the alternative category. The former may be a reflection of the fact that some managed care organizations administer multiple health plan types. The 2 organizations which classified themselves into multiple HMO and PPO categories were re-classified as "mixed HMO/PPOs." The organization which classified itself as both a group/staff model HMO and an IPA model HMO was re-classified as an "other HMO type." The 1 HMO which classified itself into the

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[283]Ibid, p. 57.

alternative category was also re-classified as an "other HMO type." The remaining 4 organizations which remained in the alternative "other" category self-identified as "networks" or "network administrators." *Figure 2* provides a summary of the distribution of structural types and sub-types among the managed care organizations which responded.

Figure 2: Representation of Organization Types
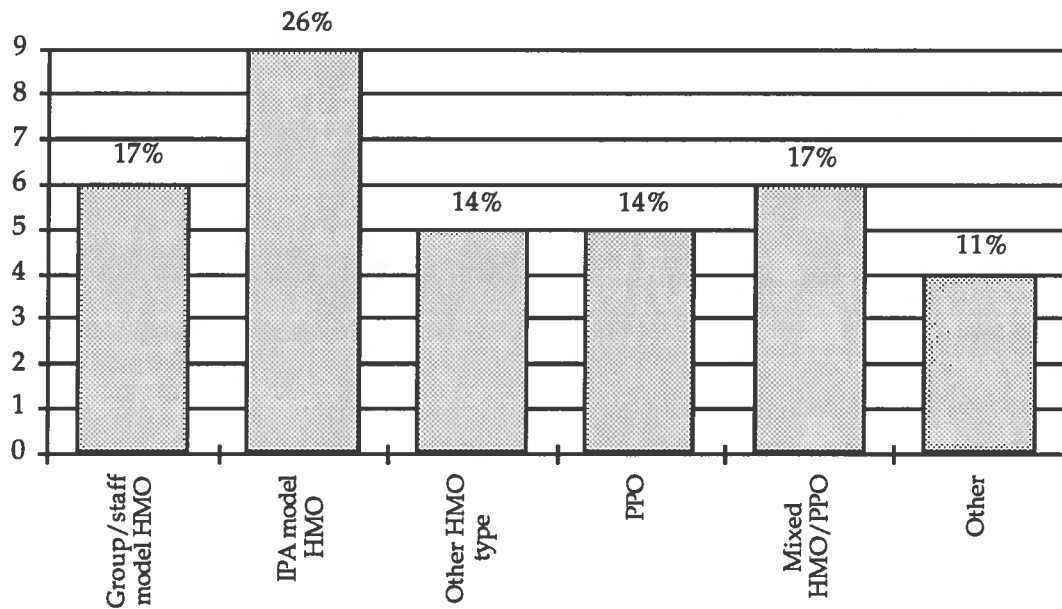
- *For profit/non-profit status:*

   This data was presented in the previous section comparing the respondent group to the non-respondent group with respect to this variable. It is summarized in *Table 1B* and *Figure 1B*. To reiterate the results, 21 organizations (60%) identified as for profit whereas 14 (40%) identified as non-profit.

- *Relationship between organization and primary care physicians:*

   This variable was intended to provide an indication of administrative authority over and accountability to physicians affiliated with organizations. Four defined categories and a fifth alternative category were provided: 1) *employer-employee*, 2) *contractual arrangement*, 3) *autonomous physician group affiliated exclusively with the responding organization*, 4) *autonomous physician group affiliated with the responding*

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organization and others, and 5) *"other,"* to be described. The variable proved to be unreliable, primarily because many respondents classified themselves into more than one category. As a result, data from this section has been excluded from the study.

- *Geographical distribution of membership:*

Organizations were asked to approximate the proportion of their members living in each of four geographical categories: 1) *inner city* (defined as an economically depressed urban location), 2) *urban* (non-inner city), 3) *suburban*, and 4) *rural*. 26 organizations (74% of the total number of responding organizations) completed this question. The central tendency and dispersion results are summarized numerically and graphically in *Table 2* and *Figure 3*, respectively.

Clearly, there was considerable variation in the range of membership service areas from one organization to another. This was true for all of the geographical categories available, with the exception of the "rural" category (in which none of the organizations indicated a representation among membership of greater than 20%).[284] The "inner city" category provides an example of the diversity of ranges of geographical sites served by individual organizations. While the mean for "inner city" composition of membership was 27.9%, organizations which responded indicated a range from 0% to nearly 100%.

Table 2: Mean Geographical Distribution of Organization Membership in Percentage (n=26)

Geographical type:	Inner city	Urban	Suburban	Rural
Mean	27.9	30.1	36.0	6.0
Standard deviation	*28.1*	*22.5*	*28.4*	*5.2*

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[284]The low representation of members in rural geographies among organizations surveyed is consistent with data on the general population of California, for which the representation of rural geographies was estimated at 7.4% in 1990 (U.S. Bureau of the Census, Statistical Abstracts of the United States: 1991, 112th ed., Washington DC, p. 27).

Figure 3: Geographical Distributions of Organization Membership

Area Type
(Quantiles: 90%, 75%, 50%, 25%, 10%)
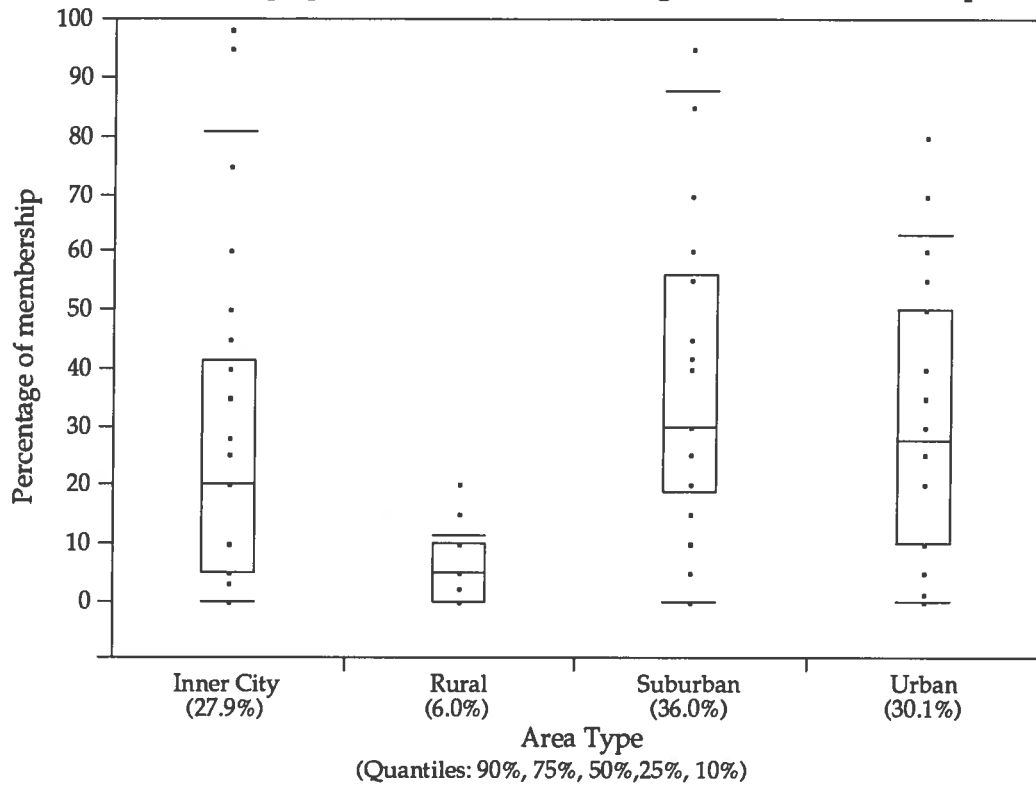
- *Proportion of physicians in primary care specialties:*

    This data was briefly presented in the above section discussing characteristics of the respondent population in relation to the non-respondent population. Summary results for organizations responding are provided in *Table 1C* and *Figure 1C*. In the survey questionnaire, organizations were asked to indicate which percentage range represented the proportion of full-time physicians (employed by or otherwise affiliated the responding organization) who practiced in primary care specialties. Primary care specialties were defined by standard criteria, which includes the fields of family practice, internal medicine, obstetrics and gynecology, and general pediatrics. Of the 29 organizations (83%) completing this question, the greatest proportion of them, 15 (52%) indicated that they employed between 20-39% in primary care specialties. The remaining organizations classified themselves relatively evenly into all four the other categories, with 3 of them (10%) indicating a primary care physician representation of 80% or more.

- *Ethnic representation among clinical physicians, non-physician clinicians, and non-clinical staff, as well as availability and reliability of such data:*

Organizations were asked to indicate (or estimate) the percentage representation of six ethnic categories among three different health professional groups: 1) *full-time clinical physicians*, 2) *full-time non-physician clinicians* (including registered nurses, nurse practitioners, licensed vocational nurses, physician assistants, etc.), and 3) *non-clinical staff with public contact*. The six categories of ethnicity included: African-American or Black, Hispanic or Latino, Asian or Pacific Islander, Native American, "other" non-White minorities, and White. In addition, organizations were asked to rate the reliability of the data provided into three categories: 1) "completely confident" (figures verified by checking numerical data file), 2) "fairly confident" (numerical data was either incomplete or not up-to-date), or 3) "not confident" (numerical data was unavailable to verify figures offered).

A summary of the results regarding the perceived reliability of information on ethnic group representation among health professional groups is provided in *Table 3*.

Table 3: Reliability of Data on Ethnic Group Representation Among Clinical and Non-Clinical Employees with Public Contact

Level of reliability:		Not confident-estimates not provided	Not confident-estimates provided	Fairly confident	Completely confident
Clinical physicians	n	15	6	8	6
	%	42%	17%	23%	17%
Non-physician clinicians	n	17	6	6	6
	%	49%	17%	17%	17%
Non-clinical staff	n	14	5	9	7
	%	40%	14%	26%	20%

As is evident in these results, the majority of organizations did not have numerical data available on ethnic group representation among their clinical and non-clinical employees with public contact. 21 organizations (60%) did not have numerical data for clinical physicians, 23 (66%) lacked such data for non-physician clinicians, and 19 (54%) did not have such data for non-clinical staff. Moreover, many organizations either were

unable to or chose not to provide an estimate of such data. 15 organizations (42%) did not provide any data for clinical physicians, 17 organizations (49%) did not provide data for non-physician clinicians, and 14 organizations (40%) did not provide data for non-clinical staff. Only 6 organizations (17%) stated that they had complete and reliable data on the ethnic representation of both physicians and non-physician clinicians. Similarly, only 7 organizations (20%) had complete and reliable data for non-clinical staff.

Table 4A: Mean Percentage Ethnic Group Representation Among Clinical Physicians (n=20)

Ethnic category:	African-American	Latino	Asian/Pacific Islander	Native American	Other non-White minority	White
Mean	5.4	8.2	19.1	0.8	3.2	63.4
Std deviation	*5.4*	*5.8*	*20.2*	*1.6*	*4.6*	*19.2*

Figure 4A: Organizational Distribution of Ethnic Group Representation Among Clinical Physicians (n=20)

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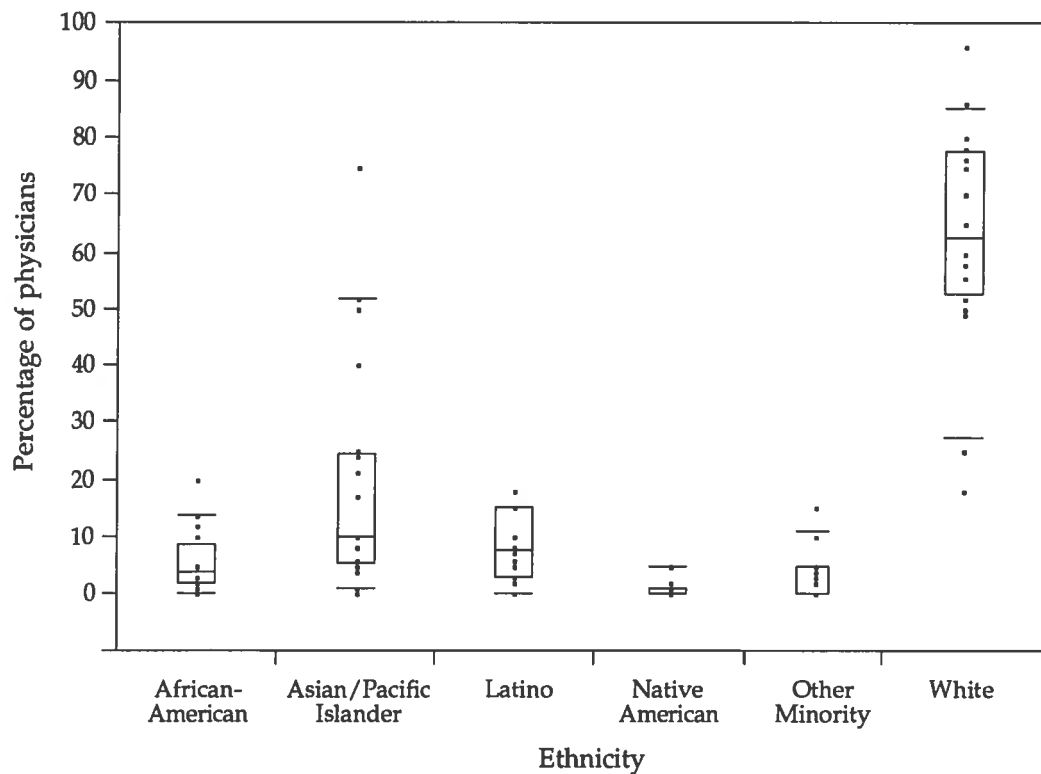
Table 4B: Mean Percentage Ethnic Group Representation Among Non-Physician Clinicians (n=18)

Ethnic category:	African-American	Latino	Asian/ Pacific Islander	Native American	Other non-White minority	White
Mean	13.2	17.0	18.5	0.8	4.5	46.5
Std deviation	*10.9*	*15.8*	*23.7*	*1.7*	*7.4*	*23.2*

Figure 4B: Organizational Distribution of Ethnic Group Representation Among Non-Physician Clinicians (n=18)
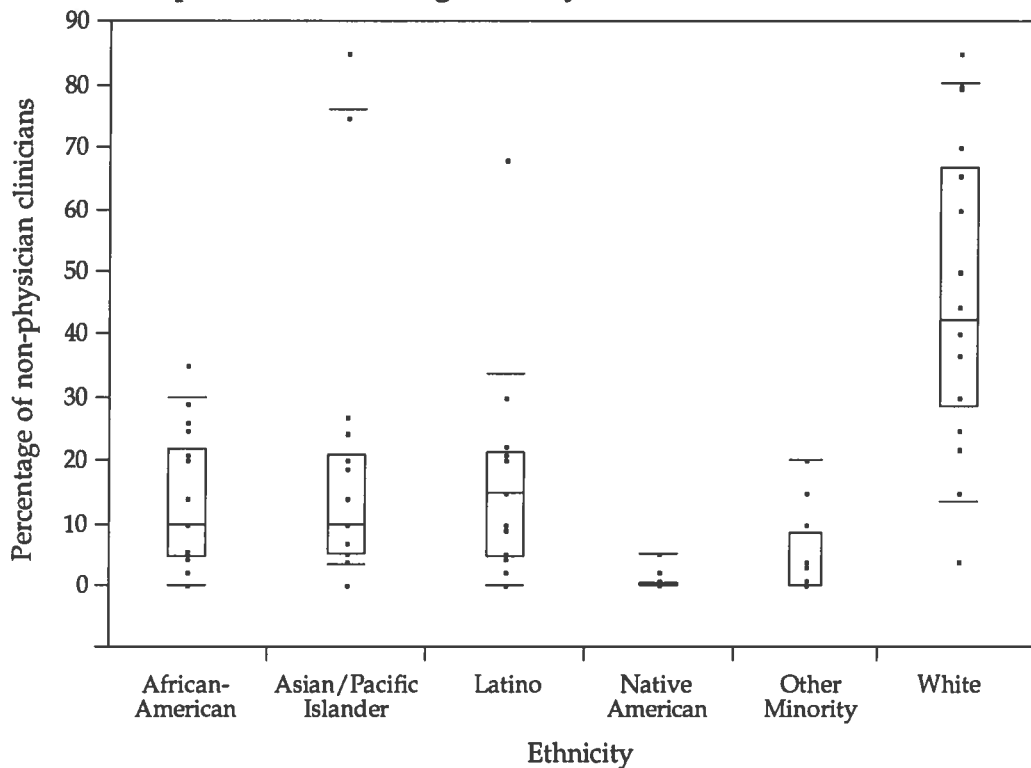
For those organizations which did provide confirmed numerical data or estimates of ethnic group representation among employees with public contact, *Tables 4A-4C* and *Figures 4A-4C* provide descriptive results of central tendency and dispersion in numerical and graphical formats, respectively.

It is evident from these results that there was considerable variation in the ethnic composition of clinical and non-clinical staff from organization to organization. This was particularly true for the non-physician clinician and non-clinical staff categories, with all of the ethnic group categories (except for Native Americans) showing wide

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variation in representation from organization to organization. Native Americans were not represented at all among any of the three professional categories in the overwhelming majority of organizations.

Table 4C: Mean Percentage Ethnic Group Representation Among Non-Clinical Staff (n=21)

Ethnic category:	African-American	Latino	Asian/ Pacific Islander	Native American	Other non-White minority	White
Mean	11.8	19.1	16.2	0.8	5.5	47.8
Std deviation	10.9	15.8	21.8	1.6	9.4	23.3

Figure 4C: Organizational Distribution of Ethnic Group Representation Among Non-Clinical Staff (n=21)
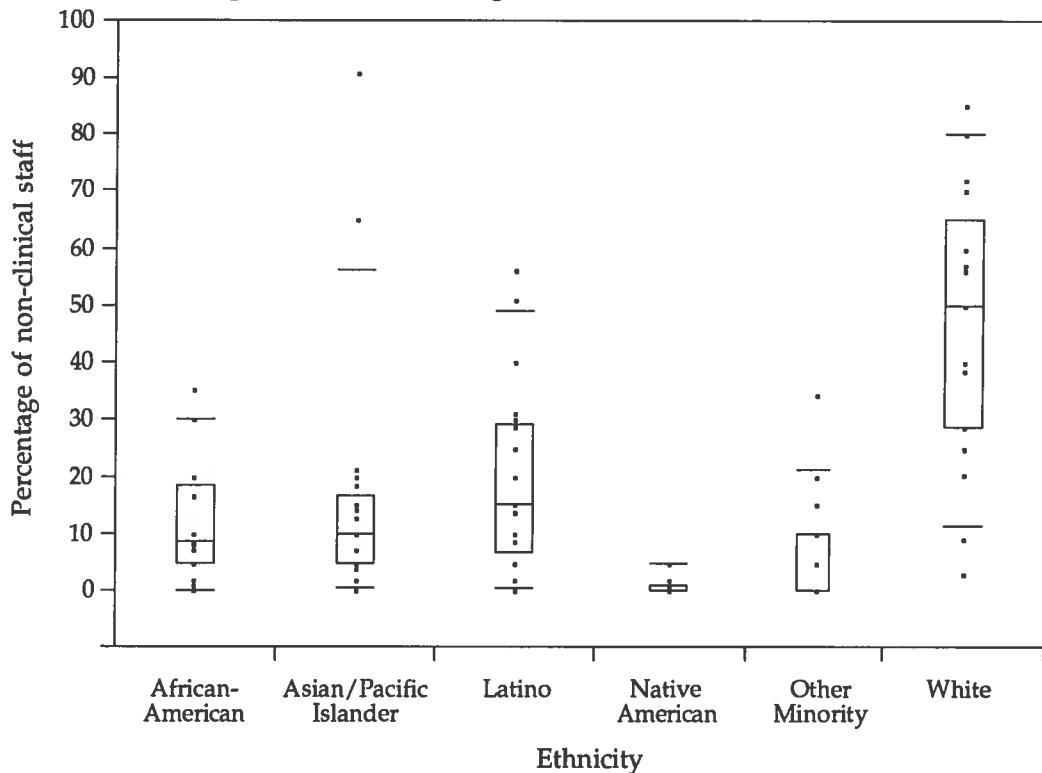
Within the physician category, there was less variation in ethnic composition between organizations, particularly for the White, African-American, and Latino groups. With 2 exceptions, White physicians comprised a majority in all organizations. There were no organizations in which African-American or Latino physicians comprised more than 20% of the total. Furthermore, the physician category had the lowest overall

representation of these two groups (a fact which is consistent with numerous state and national studies).[285]

- *Ethnic group composition of governing board:*

Each organization was asked to indicate the number of members of its governing board who were members of each of the six ethnic categories defined in the previous section, as well as the total number of board members. 27 organizations (77% of the total number of respondents) provided such data. The raw numerical data were converted to percentage data for comparison purposes (as board size varied considerably). Summary distribution data are provided in *Table 5* and *Figure 5*.

With few exceptions, the representation of non-White minority members on the governing boards was low. 16 of the 27 organizations providing such data (59%) indicated that White members constituted 100% of the composition of their boards. In only 3 of the 27 organizations (11%) did White members constitute less than 50% of the board member composition. In all 3 of these organizations, members of a single non-White ethnic minority category constituted greater than 50% of the board membership: in one case, 100% of the board members were identified as Latino; in the second, 62% of the members were African-American; in the third, 57% of the members were Asian or Pacific Islander. Of additional note is the fact that there were no Native American members on any of the governing boards of organizations providing data.

Table 5: Mean Percentage Ethnic Group Representation Among Governing Board Members (n=27)

Ethnic category:	African-American	Latino	Asian/ Pacific Islander	Native American	Other non-White minority	White
Mean	3.8	7.6	2.7	0.0	1.1	84.8
Std deviation	12.5	20.1	11.2	0.0	3.9	26.5

[285]California Systems Capacity Task Force, p. 36; Kehrer and Burroughs, p. 13. For Blacks, representation in California among physicians is 3.5%, among physician assistants is 5.7%, and among registered nurses is 7.7%. For Hispanics, representation among physicians is 5.6%, among physician assistants is 16.0%, and among registered nurses is 7.6%.

Figure 5: Organizational Distribution of Ethnic Group Representation Among Governing Board Members (n=27)
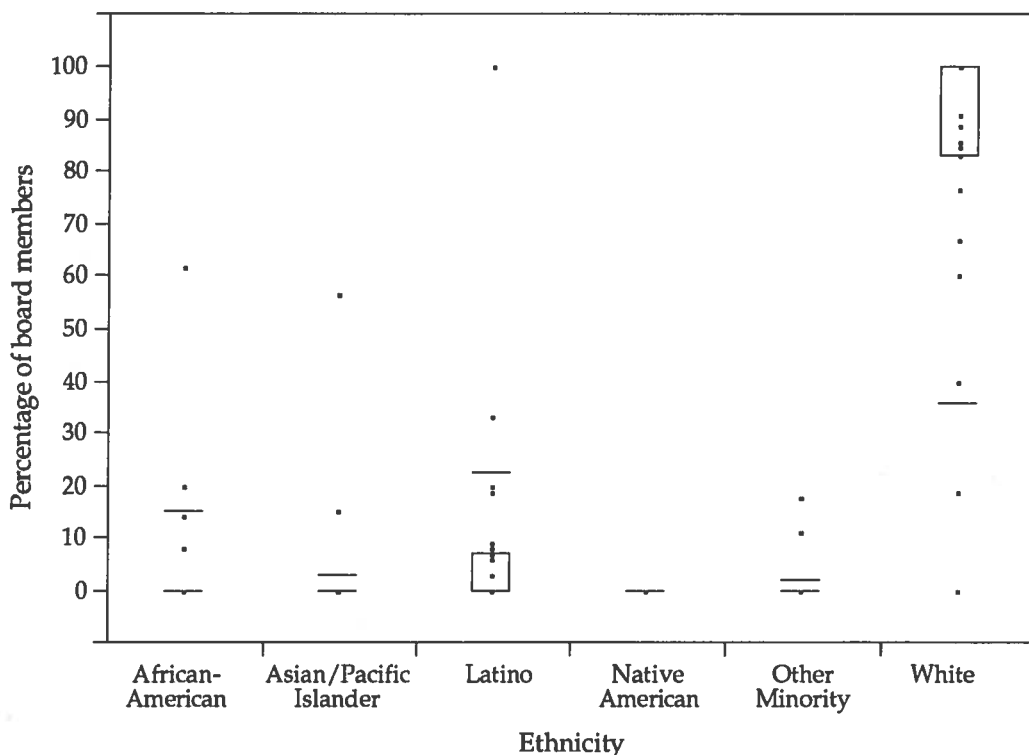
• *Bilingualism/multilingualism among clinicians and non-clinical staff with public contact:*

Organizations were asked to indicated, by percentage range, the proportion of their clinicians and non-clinical staff who were bilingual or multilingual (defined as fluency in both English and at least one other language). *Figure 6* provides a graphical summary of the results. 10 of the organizations (29%) responded that they did not maintain such data and therefore did not indicate ranges for either group. Of those organizations which did respond, the greatest number indicated that between 10-19% of both clinicians and non-clinical staff were bilingual or multilingual. 2 organizations (6%) indicated that less than 10% of their clinicians and non-clinical staff were bilingual or multilingual. 4 organizations (11%) indicated that 40% or more than 40% of their clinicians were bilingual or multilingual. 5 organizations (14%) indicated this range of bilingualism/multilingualism for their non-clinical staff.

Figure 6: Bilingualism/Multilingualism Among Clinicians and Non-Clinical Staff (n=35)
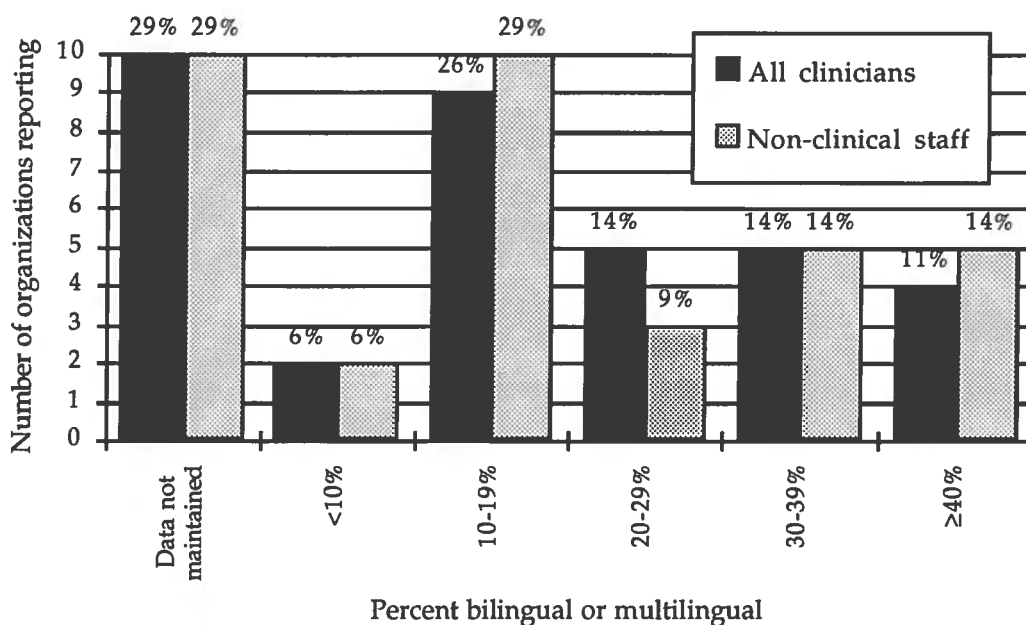
- *Ethnic group representation among membership:*

Organizations were asked to indicate or approximate the percentage of their enrolled members who were members of the six ethnic categories described above. In addition, they were asked to provide an indication of the level of reliability of this data (i.e. "completely confident," "fairly confident," and "not confident" categories were provided). Of the 35 organizations participating in the survey, only 5 (14%) of them indicated that they were "completely confident" in the figures provided. 7 (20%) of them indicated that they were "fairly confident" in the figures provided. 23 (66%) of them indicated that they were "not confident" in their ability to provide data on the ethnic composition of their membership. Of these 23 organizations, only 7 provided estimates of this data. As a result, only 19 out of the 35 organizations surveyed (54%) provided confirmed numerical figures or estimates of the ethnic composition of their membership. *Table 6* and *Figure 7* provide descriptive results for those 19 organizations offering information to this section.

Table 6: Mean Percentage Ethnic Group Representation Among Membership of Organizations (n=19)

Ethnic category:	African-American	Latino	Asian/Pacific Islander	Native American	Other non-White minority	White
Mean	13.8	23.6	11.7	0.8	4.6	46.9
Std deviation	*14.2*	*15.1*	*19.1*	*1.6*	*5.3*	*27.6*

Figure 7: Organizational Distribution of Ethnic Group Representation Among Membership (n=19)
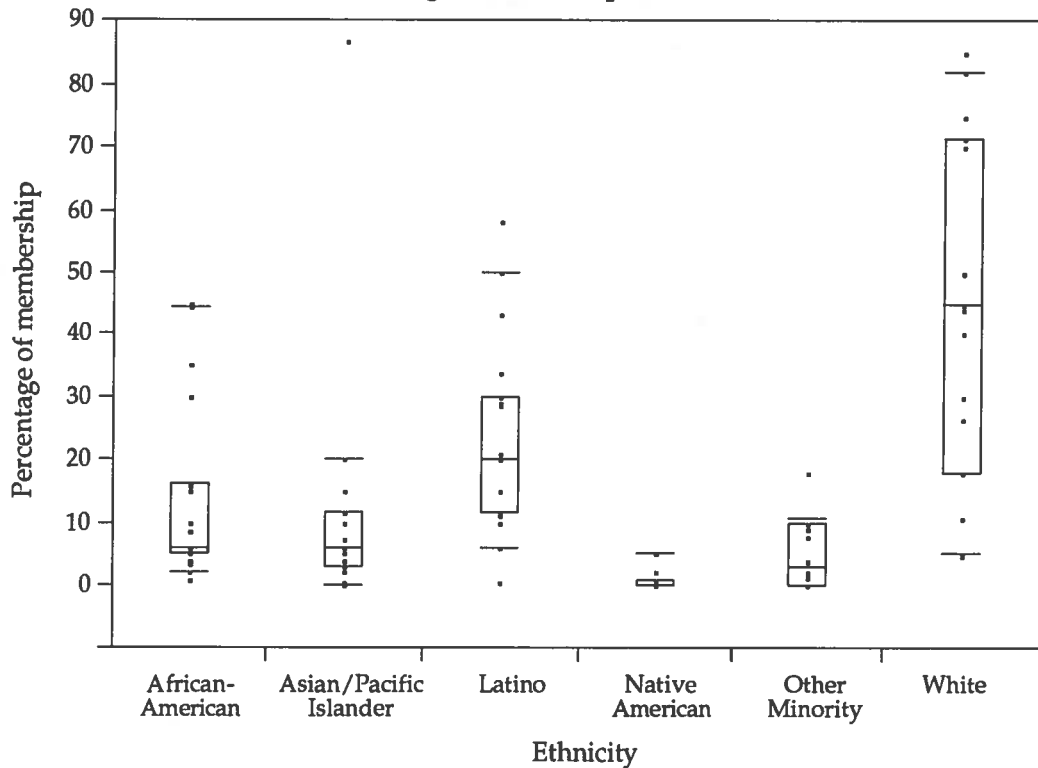
Examining the data in *Table 6*, one finds that, on average, organizations providing data had membership populations which were fairly consistent with the ethnic group composition of California's population as a whole. California's ethnic minority composition is 26% Hispanic, 9% Asian, 7% African-American and 1% Native American and other minority groups.[286] Of course, as the figures in *Table 6* merely represent mean figures when weighing all organizations equally (without attempting to

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[286]U.S. Bureau of the Census, <u>Statistical Abstracts of the United States: 1991</u>, 111th ed., Washington, DC.

compensate for the wide variations in organization size) they should not be interpreted as in any way being representative of the aggregate ethnic composition of members in all of the organizations providing data.

When comparing the data in *Table 6* to data in *Tables 4A-4C*, which provide figures on mean organization to organization ethnic group representation among physicians, non-physician clinicians, and non-clinical staff, one finds another trend which is notable. For all three categories of health professionals and staff, the representation of African-Americans and Latinos is, on average, lower than their representations among the memberships of organizations. In contrast, on average, Asians and Pacific Islanders show a higher representation in all three categories of health professionals and staff than among members of organizations.

Of additional note is that fact that there was wide variation in the percentage membership representation of ethnic groups from organization to organization. For example, non-White minorities (African-Americans, Asian and Pacific Islanders, Latinos, Native Americans, and other non-White minorities in aggregate) constituted less than 20% of the member population of 2 organizations, but also constituted greater than 95% of the member population of 2 other organizations. Among those organizations in which non-White minorities represented a large proportion of the membership, there was also considerable variation in the relative representation of each non-White minority group. For example, one organization's membership was 87% Asian and Pacific Islander with other non-White minority groups comprising less than 3% of the population. Other organizations had memberships which more closely resembled that of California's population as a whole. However, in all organizations, at least one group was significantly disproportionately represented in comparison to California's population as a whole.

- *Proportion of members that are non-English speaking or proficient:*

Survey participants were asked to indicate the percentage range of members enrolled in their organizations who were non-English speaking (NES) or non-English proficient (NEP). The results are provided in *Figure 8*. Of note is the fact that 17 organizations (49%) indicated that they did not maintain such data. Of the 18 organizations which did provide data, the greatest number of them, 7 (39%), indicated that less than 10% of their member population was NES or NEP. In contrast, 4 organizations (22% of those providing data) indicated that 40% or more members were NES or NEP.

Figure 8: Proportion of Members Non-English Speaking or Proficient (n=18)

Proportion of membership which is non-English speaking or proficient
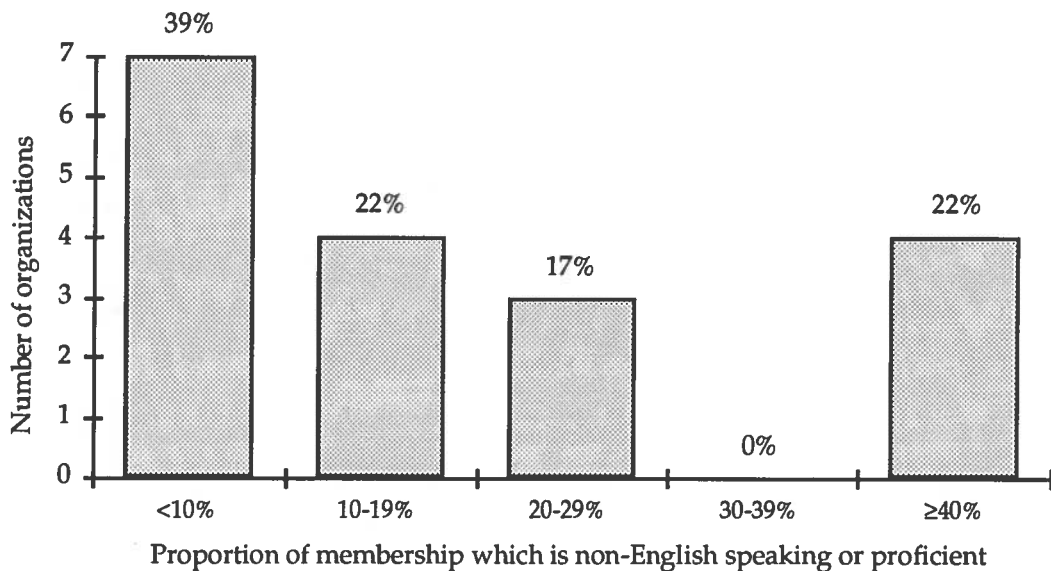
- *Proportion of members that are Medi-Cal recipients:*

Participants were asked to indicate what percentage range of their members were recipients of Medi-Cal benefits. 34 organizations completed this question. The results are provided in *Figure 9*. 35% of the organizations indicated that none of their members were Medi-Cal recipients and 47% indicated a range of 1-19%. Only 2 organizations (6%) indicated ranges of 20% or higher, with 1 of these indicating that 80-100% of its members were Medi-Cal recipients.

Figure 9: Proportion of Members Receiving Medi-Cal (n=34)
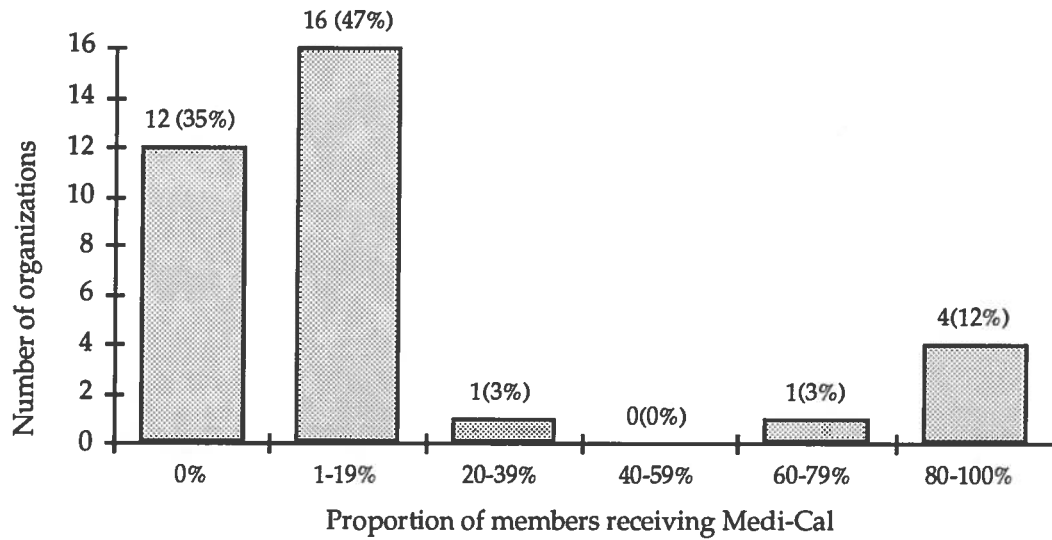
- *Demographics of general population in geographical service area:*

Participants were asked to indicate the availability of data on six variables relating to the demographic composition of the general geographical service areas of their organizations (i.e. not limited to their own memberships). These six variables were: 1) *ethnic composition,* 2) *education level,* 3) *number of NES and NEP households,* 4) *Aid for Dependent Children (AFDC) recipient percentage,* 5) *Medi-Cal eligible, enrollee, and user percentage,* and 6) *gender and age breakdown of Medi-Cal eligible population.* Data availability was self-rated into one of three categories: 1) "have almost no such data," 2) "have approximate but not precise data," or 3) "have detailed and accurate data." The results are summarized numerically and graphically in *Table 7* and *Figure 10,* respectively.

Most organizations indicated that they had some form of data on the ethnic composition of the general population in the geographical service area, with only 15% indicating that they had almost no such data. In contrast a large number of organizations indicated that they had almost no data on the five remaining general population variables: 38% indicated this level of data availability for the education level of the general population; 35% indicated this for the number of NES and NEP

households; 39% indicated this for the AFDC recipient percentage; 29% indicated this for the Medi-Cal eligible, enrollee, and user percentage; and 38% indicated this for the gender and age breakdown of Medi-Cal eligibles.

Table 7: Availability of Demographic Information on General Population in Geographic Service Area (n=34)

Availability of data:		Have almost no such data	Have approxi-mate but not precise data	Have detailed & accurate data
Ethnic composition	n	5	17	12
	%	15%	50%	35%
Education level	n	13	12	9
	%	38%	35%	26%
NES and NEP households	n	12	15	7
	%	35%	44%	21%
AFDC recipients	n	13	8	12
	%	39%	24%	36%
Medi-Cal eligibles, enrollees, and users	n	10	11	13
	%	29%	32%	38%
Gender and age of Medi-Cal eligibles	n	13	10	11
	%	38%	29%	32%

Figure 10: Availability of Demographic Information on General Population in Geographic Service Area (n=34)

Type of data on general population in geographical service area
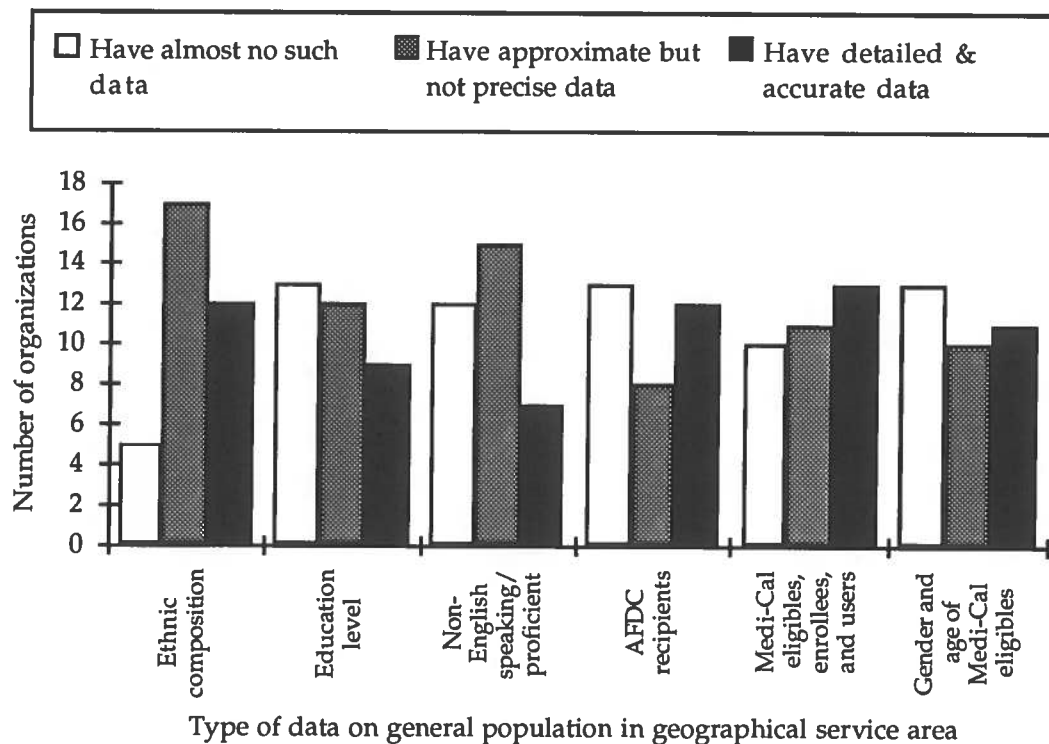
In contrast, a number of organizations indicated that they did have detailed and accurate data for certain general population demographic variables. The three demographic variables for which organizations most frequently indicated that they had detailed and accurate data were: 1) Medi-Cal eligible, enrollee, and user percentage (38% of participants), 2) AFDC recipient percentage (36%), 3) and ethnic composition (35%).

- *Community linkages:*

Organizations were asked to indicate the proportion of their clinical sites which were engaged in linkages with community organizations. Five categories of linkages were assessed: 1) *subcontractual relationships*, 2) *planning and policy partnerships*, 3) *community organizations and/or individuals serving in a formal advisory capacity*, 4) *formal arrangements for providing referrals to community organizations*, and 5) *community organizations and/or individuals formally participating in organization evaluation*. A *clinical site* was defined as "any geographically distinct center at which health services of any type are provided, whether in-patient or out-patient." Examples of community organizations were also provided in the questionnaire. The number of organizations providing such data was somewhat disappointing, with anywhere between 21 and 23 of them providing responses for each of the five categories. The results are summarized in *Table 8* and *Figure 11*.

Table 8: Proportion of Clinical Sites with Community Linkages (n=21 to 23)

| Proportion of sites:		No sites	Few sites	Half of sites	Most sites	All sites	Total
Subcontractual	n	6	8	0	0	9	23
	%	26%	35%	0%	0%	39%	100%
Planning & policy	n	6	7	0	1	7	21
	%	29%	33%	0%	5%	33%	100%
Community advising	n	7	6	2	2	5	22
	%	32%	27%	9%	9%	23%	100%
Referrals to community	n	6	6	0	3	7	22
	%	27%	27%	0%	14%	32%	100%
Community evaluation	n	12	3	0	0	6	21
	%	57%	14%	0%	0%	29%	100%

Figure 11: Proportion of Clinical Sites with Community Linkages (n=21 to 23)
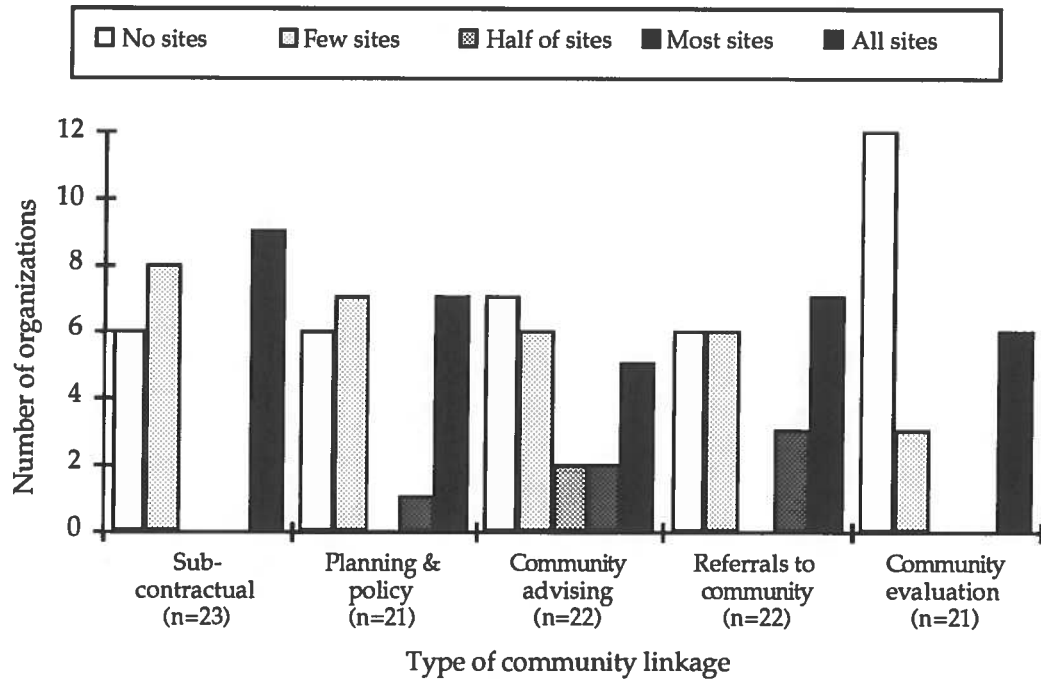
In general, organizations tended to engage in such linkages at either no clinical sites, few sites, or all sites. Few organizations indicated that they engaged in any of the linkage types at half of or most of their clinical sites. Overall, the majority of organizations engaged in the various linkage types in a very limited capacity. 61% of responding organizations engaged in subcontractual linkages at no or few sites, 62% engaged in planning and policy linkages at no or few sites, 59% involved community advising at no or few sites, and 54% provided referrals to community organizations at no or few sites. Of particular note is the fact that 57% of the responding organizations had no formal means for community evaluation at any of their clinical sites.

• *Culture-related services offered at clinical sites:*

Participants were asked to indicate the proportion of their organizations' clinical sites offering each of 13 types of services which were considered central in the CCTF definition (as well as in other definitions) of culturally competent health care provision at the managed care organization level. Included were a broad range of service types, ranging from interpreter and translator services to culture matching of clinicians and

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patients. For the purposes of this section of the discussion, they will be referred to simply as "culture-related services." The results of this portion of the survey are summarized in *Table 9* and *Figures 12A-12C*.

Five of the service types assessed were related to provision of services to non-English speaking patients. They included the utilization of translators and/or interpreters of Spanish, Chinese dialects, other Southeast-Asian languages, and other languages not specified, as well as the utilization of non-English forms and other written materials. With the exception of Spanish interpreters and/or translators, relatively few organizations offered interpreter and/or translator services at more than a few sites. However, 62% of organizations responding did indicate that they offered forms and other written materials in non-English languages at "most" or "all" clinical sites.

Utilization or alliance with indigenous health systems and/or healers was the least practiced service overall. Only 1 organization reported such services at "all" clinical sites with all others reporting such services at "no" or "few" sites. The use of culture brokers and/or lay health advisors was also uncommon overall, with only 18% of organizations offering such services at more than "half of" clinical sites and 41% not offering such services at any sites.

The following services tended to follow an overall bimodal distribution between organizations: mechanisms for increased time allocation when cultural barriers present, courses and/or training programs for clinical employees, grievance procedures specific to issues involving cultural factors, and patient-clinician "culture matching" mechanisms. The majority of organizations either offered these services at "no" clinical sites or at "all" clinical sites. This could be a reflection of at least one of two things: 1) a number of organizations had relatively few clinical sites, and therefore such services were offered either at very few or at all sites or 2) that organizations offered such services as a result of formalized institutional policies, therefore affecting either all clinical sites or none of them. If the latter is true, services which tended to be offered

over a broader range of clinical sites (i.e. "few," "half," or "most" sites), such as

flexibility in scheduling patients with non-traditional schedules, would perhaps be less

likely to be in place as a result of formalized institutional policies.

Table 9: Proportion of Clinical Sites Providing Culture-Related
Services (n=20 to 24)

Proportion of clinical sites providing service:		No sites	Few sites	Half of sites	Most sites	All sites	Total
1) Spanish interpreters/ translators utilized	*n*	1	6	5	7	5	24
	%	4.2	25.0	20.8	29.2	20.8	100
2) Chinese dialect interpreters/translators utilized	*n*	2	16	1	2	3	24
	%	8.3	66.7	4.2	8.3	12.5	100
3) Other Southeast-Asian language interpreters/ translators utilized	*n*	3	16	1	2	2	24
	%	12.5	66.7	4.2	8.3	8.3	100
4) Interpreters/translators for other languages utilized	*n*	4	14	1	2	2	23
	%	17.4	60.9	4.3	8.7	8.7	100
5) Forms/written materials available in non-English languages	*n*	2	5	2	4	11	24
	%	8.3	20.8	8.3	16.7	45.8	100
6) Indigenous health systems/healers utilized by/allied with	*n*	15	7	0	0	1	23
	%	65.2	30.4	0.0	0.0	4.3	100
7) Mechanisms for increased time allocation when cultural barriers present	*n*	9	5	1	3	5	23
	%	39.1	21.7	4.3	13.0	21.7	100
8) Flexibility in scheduling for patients with non-traditional schedules	*n*	2	4	6	4	7	23
	%	8.6	17.4	26.1	17.4	30.4	100
9) Travel accommodations for non-English speaking/ proficient patients	*n*	8	3	3	2	4	20
	%	40.0	15.0	15.0	10.0	20.0	100
10) Courses/training programs for clinical employees	*n*	7	5	1	2	7	22
	%	31.8	22.7	4.5	9.1	31.8	100
11) Procedures for grievances specifically involving culture-related issues	*n*	4	5	1	2	11	23
	%	17.4	21.7	4.3	8.7	47.8	100
12) Culture brokers and/or lay health advisors utilized	*n*	9	9	2	0	2	22
	%	40.9	40.9	9.1	0.0	9.1	100
13) Patient-staff matching mechanisms utilized	*n*	4	8	1	3	6	22
	%	18.2	36.4	4.5	13.6	27.3	100

Figure 12A: Proportion of Clinical Sites Providing Language Related Services (n=23 to 24)

Legend: ☐ No sites ☐ Few sites ☒ Half of sites ■ Most sites ■ All sites

Y-axis: Number of organizations

X-axis (Type of service): Spanish translators/interpreters (n=24); Chinese translators/interpreters (n=24); SE-Asian translators/interpreters (n=24); Other translators/interpreters (n=23); Written materials in non-English (n=24)
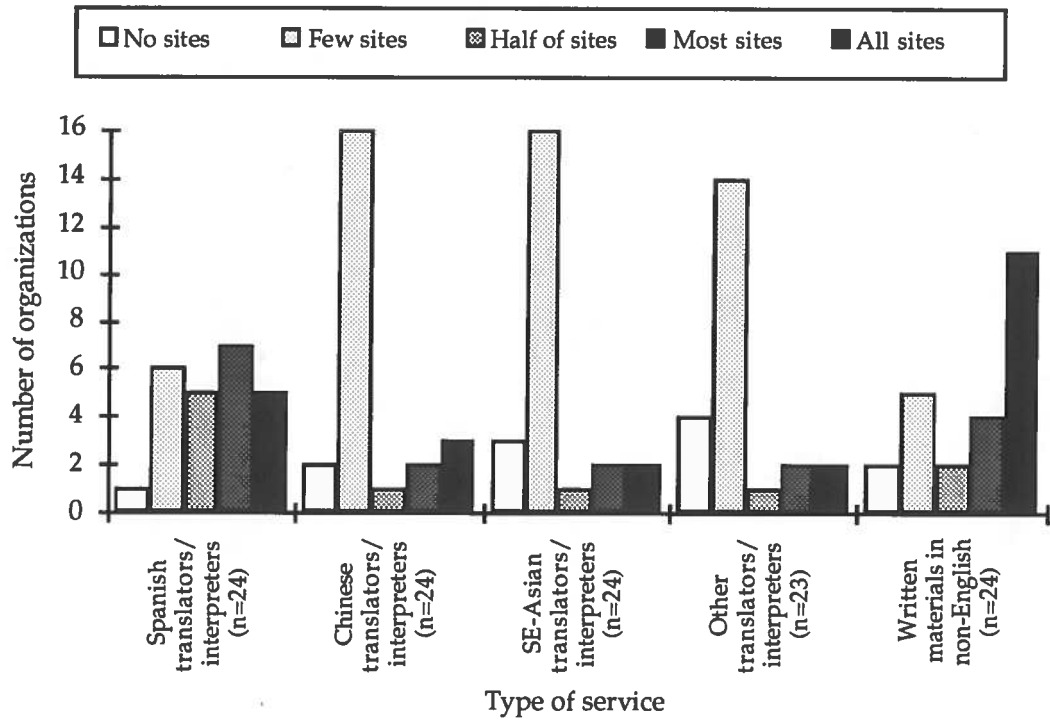
Figure 12B: Proportion of Clinical Sites Providing Culture-Related Services (n=20 to 23)

Legend: ☐ No sites ☐ Few sites ☒ Half of sites ■ Most sites ■ All sites

Y-axis: Number of organizations

X-axis (Type of service): Indigenous health systems/healers utilized (n=23); Increased time allocation when cultural barriers present (n=23); Flexibility for patients w/ non-traditional schedules (n=23); Travel accomodations for NES/NEP patients (n=20)

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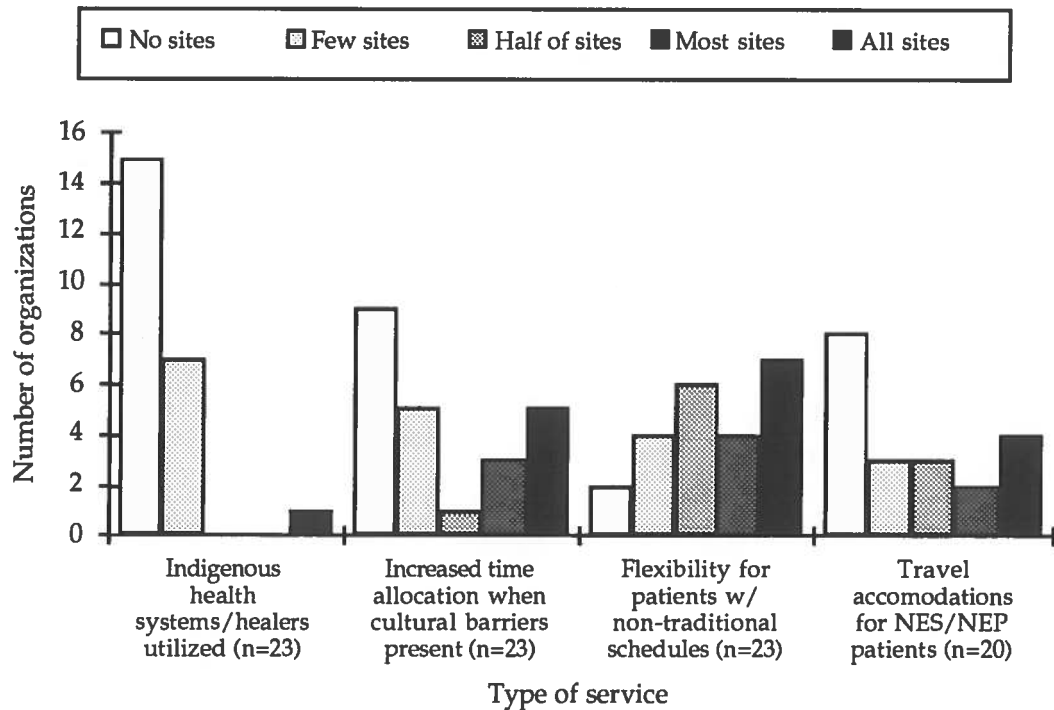
Figure 12C: Proportion of Clinical Sites Providing Culture-Related Services (n=22 to 23)

Legend: ☐ No sites ☐ Few sites ⊠ Half of sites ■ Most sites ■ All sites

Y-axis: Number of organizations (0 to 12)

X-axis (Type of service):
- Courses/training programs for clinicians (n=22)
- Procedures for culture-related grievances (n=23)
- Culture brokers/lay health advisors (n=22)
- Patient-staff matching mechanisms utilized (n=22)
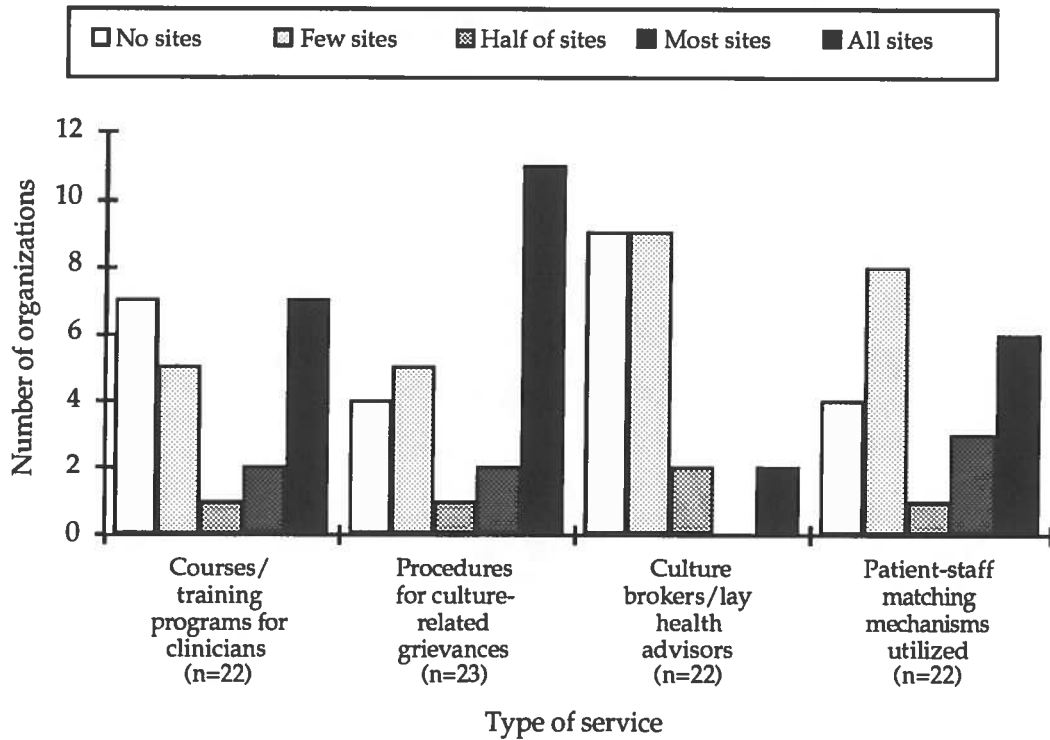
- *Knowledge, perceptions, and opinions of administrators:*

With few exceptions, all administrators who were surveyed completed the last section of the questionnaire. This section consisted of 10 closed-ended questions relating to health care provision for culturally diverse populations. An appended version of each question, as well as responses to each question will be briefly discussed below.

1) "In your experience as a health care administrator, to what extent have you found cultural factors among minority populations to be significant barriers to access to health care?"

Response	Number of Respondents	Percentage of Respondents
Not barriers	0	0
Minor barriers	7	20
Significant barriers	16	46
Very important barriers	11	31
The most important barriers	1	3
Total	35	100

80% of those responding felt that cultural factors among minority populations were "significant," "very important," or "the most important" barriers to health care access. None of the respondents felt that they were not barriers.

2) "In your opinion, how much of a priority is it for health care provider organizations to engage in efforts, at an administrative/policy level, which will improve access to health care for culturally different populations?"

Response	Number of Respondents	Percentage of Respondents
Not a priority	0	0
Low priority	2	6
Moderate priority	12	36
High priority	16	48
Highest priority	3	9
Total	33	100

94% of those responding felt that such efforts were of at least of "moderate" priority. 57% felt that such efforts were of "high" or "highest" priority.

3) "How well equipped do you feel your organization is to provide services for a culturally and ethnically diverse population?"

Response	Number of Respondents	Percentage of Respondents
Not at all equipped	0	0
Inadequately equipped	3	9
Moderately equipped	23	66
Well equipped	3	9
Exceptionally well equipped	6	17
Total	35	100

91% of participants felt that their organizations were at least "moderately" equipped to provide services to culturally and ethnically diverse populations. 17% felt that their organizations were "exceptionally" well equipped.

4) "In your practice as a health care administrator, how frequently have you heard the term *cultural competency* utilized?"

Response	Number of Respondents	Percentage of Respondents
Never	11	32
Seldom	4	11
Occasionally	11	32
Regularly	6	18
Daily	2	6
Total	34	100

32% of respondents had never heard the term used in a health administration

context. In contrast, 24% heard the term utilized "regularly" or "daily."

5) "How confident are you in your knowledge of what cultural competency is, *in general?*"

Response	Number of Respondents	Percentage of Respondents
Not at all confident	10	29
Slightly confident	2	6
Moderately confident	14	41
Highly confident	5	15
Completely confident	3	9
Total	34	100

24% of respondents were "highly" or "completely" confident of their knowledge

of the general meaning of the term. 29% were "not at all confident."

6) "How confident are you that you know *what specific factors contribute to* cultural competency at an administrative/organizational level?"

Response	Number of Respondents	Percentage of Respondents
Not at all confident	10	29
Slightly confident	6	18
Moderately confident	13	38
Highly confident	4	12
Completely confident	1	3
Total	34	100

Fewer respondents were as confident of their knowledge of what specific factors

were components of culturally competent care at an administrative level, with only 1

respondent indicating "complete confidence."

7) "How desirable is the goal of health care organizations becoming more culturally competent?"

Response	Number of Respondents	Percentage of Respondents
Not at all desirable	0	0
Slightly desirable	0	0
Moderately desirable	9	26
Very desirable	17	50
Extremely desirable	8	24
Total	34	100

All of the respondents felt that this goal was at least "moderately" desirable.

74% felt that it was "very" or "extremely" desirable for health care organizations to

become more culturally competent.

8) "How necessary do you feel it is for managed care organizations and other health care providers to be *required* to take measures to make their practices more culturally competent?"

Response	Number of Respondents	Percentage of Respondents
Extremely unnecessary	5	15
Not necessary	10	30
Somewhat necessary	7	21
Very necessary	7	21
Extremely necessary	4	12
Total	33	100

There was wide variation in responses to this question. 45% of respondents felt that it was "extremely unnecessary" or "not necessary" for health care providers to be required to make their practices more culturally competent. In contrast, 33% of respondents felt that such action was "very" or "extremely" necessary.

9) "How cost effective do you feel efforts to increase cultural competency among provider institutions will be for those organizations in the long term?"

Response	Number of Respondents	Percentage of Respondents
Very cost ineffective	1	3
Moderately cost ineffective	2	6
Marginally cost effective	11	32
Moderately cost effective	16	47
Very cost effective	4	12
Total	34	100

59% of respondents felt that such efforts would be "moderately" or "very" cost effective. In contrast, only 9% of respondents felt that such efforts would be "moderately" or "very" cost *in*effective.

10) "How satisfied are you with the amount of information that has been provided to health care administrators by the State and/or other public institutions regarding the definition of cultural competency, and what factors contribute to an organization being and becoming culturally competent?"

Response	Number of Respondents	Percentage of Respondents
Very dissatisfied	2	6
Moderately dissatisfied	18	51
Moderately satisfied	5	14
Very satisfied	1	3
Have not been following	9	26
Total	35	100

26% of the respondents had not been following such information to an adequate degree that they had an opinion. 57% were "moderately" or "very" dissatisfied with the amount of information provided. Only 1 respondent was "very" satisfied.

Cultural competency "scores":

One of the goals of the initial plan for data analysis included the construction and validation of an index or set of indices to rate the capacity of managed care organizations to provide culturally competent care. Because of the low response rate and resulting lack of statistical power, it was determined that any effort to develop and validate such an index or set of indices through in-depth factor analysis would prove unprofitable. Nonetheless, in order to examine possible relationships between independent variables and dependent variables relating to the prevalence of culturally competent policies, practices, and structures, it was necessary to provide an alternative method for describing the various culture-related capacities of organizations. This alternative approach was to group various ordinally or quasi-ordinally defined organizational characteristics into four categories of organizational capacity and to produce an aggregate crude score of each capacity.

These four areas of organizational cultural competency capacity were: 1) a *data availability* capacity, describing the ability of each organization to numerically describe the ethnic and socioeconomic composition of its membership, its health provider employees, and the general population of its service area; 2) a *community linkages* capacity, describing the extent to which formal linkages with community organizations were developed; 3) a *language services* capacity, describing the extent to which service provision had been facilitated for non-English speaking patients; and 4) a *culturally sensitive services* capacity, describing the extent to which other services described within various definitions of culturally competent care had been implemented. The ordinal or quasi-ordinal criteria used in producing each score, as well as the overall score results for organizations providing adequate data are provided in *Table 10*.

Bivariate analysis:

Bivariate analysis was performed with the intent of identifying possible predictors of cultural competency capacities. For the purposes of minimizing the degrees of freedom for chi-square analysis, a median-split of each of the four cultural competency capacity scores observed was performed to convert each capacity into a dichotomous variable. Based upon this arbitrary division, each organization was placed into either a "high" or a "low" rating category for each capacity. Chi-square analysis was then performed, investigating possible associations between each of the four cultural competency capacities and a number of independent variables relating to organizational demographics. Independent variables for which sufficient distribution was available for such analysis included: 1) size of organization (vis-à-vis enrolled membership); 2) for-profit/non profit status; 3) proportion of members living in inner city; 4) proportion of affiliated physicians practicing in primary care specialties; 5) proportion of NES/NEP members; 6) proportion of Medi-Cal receiving members; and 7) proportion of clinical sites in areas in which minorities constitute greater than 50% of the population. Where applicable, each of these interval or ordinal variables was converted into a dichotomous variable, again based upon a median-split. In addition, chi-square analysis was performed to compare each capacity rating with the self-reported degree to which administrators perceived their organizations to be equipped to provide services to culturally and ethnically diverse populations. The results of these analyses are reported in the following sections, discussing the results of possible associations and non-associations of the independent variables studied. While associations were considered significant if the statistical chance of error was 5% or less (χ^2 of 3.84 or greater, with one degree of freedom), it should also be acknowledged that with such a small study population these stringent criteria may exclude associations which are less obvious and more likely to be suppressed by internal error factors.

- *Organization size:*

Organizations were divided into two categories: "large" (150,000 or more members) and "small" (less than 150,000 members), with 60% of organizations falling into the former category and 40% in the latter. A summary of bivariate analysis results is provided in the following *Table 11A*. The only cultural competency capacity found to have an association with organization size was the language services capacity, with smaller organizations being more likely to provide more comprehensive language services (χ^2=4.057, p=0.0440). The cross-tabulation results of this comparison are provided in *Table 11B*.

Table 11A: Organization Size and Cultural Competency Capacities

Variable	n	DF*	χ^2	p
Data availability capacity	33	1	0.247	0.6192
Community linkages capacity	20	1	0.840	0.3593
Language services capacity	23	1	4.057	0.0440
Culturally sensitive services capacity	20	1	0.840	0.3593

(*DF=degrees of freedom)

Table 11B: Organization Size and Language Capacity Cross-Tabulation

		Organization size		
		Large	Small	Row total
Language capacity	High	2	9	11
		9%	39%	48%
	Low	7	5	12
		30%	22%	52%
	Column total	9	14	23
		39%	61%	100%

- *For profit/non-profit status:*

Results of this analysis are shown in *Table 12A*. An apparent association existed between non-profit status and increased data availability (χ^2=5.488, p=0.0191) and a strong borderline relationship existed between non-profit status and increased language services capacity (χ^2=3.674, p=0.0553). Cross-tabulation results of these relationships are shown in *Table 12B* and *Table 12C*.

Table 12A: For Profit/Non-Profit Status and Cultural Competency Capacities

Variable	n	DF	χ^2	p
Data availability capacity	33	1	5.488	0.0191
Community linkages capacity	20	1	1.848	0.1740
Language services capacity	23	1	3.674	0.0553
Culturally sensitive services capacity	20	1	0.202	0.6528

Table 12B: For Profit/Non-Profit Status and Data Availability Capacity Cross-Tabulation

		For-profit/non-profit status		
		For profit	Non-profit	Row total
Data availability capacity	High	7	9	16
		21%	27%	48%
	Low	14	3	17
		42%	9%	52%
	Column total	21	12	33
		64%	36%	100%

Table 12C: For Profit/Non-Profit Status and Language Capacity Cross-Tabulation

		For-profit/non-profit status		
		For profit	Non-profit	Row total
Language capacity	High	3	8	11
		13%	35%	48%
	Low	8	4	12
		35%	17%	52%
	Column total	11	12	23
		48%	52%	100%

- *Proportion of members living in inner city geographies:*

The median reported proportion of membership living in inner city geographies was 20%. Therefore, all organizations with 20% or fewer members living in inner city geographies were considered "low" inner city representation organizations and those with more than 20% of members living in such geographies were considered "high" inner city representation organizations. The results of this analysis are presented in *Table 13A*. Among those organizations for which adequate data was available, potentially significant associations were found between organizations with high representations of inner city membership and those with higher language services capacity (χ^2=3.956,

p=0.0467) and those with higher culturally sensitive services capacity (χ^2=4.3535, p=0.0332). Cross-tabulation results of these possible associations are provided in *Table 13B* and *Table 13C*.

Table 13A: Inner City Membership Representation and Cultural Competency Capacities

Variable	n	DF	χ^2	p
Data availability capacity	24	1	1.765	0.1839
Community linkages capacity	19	1	1.369	0.2419
Language services capacity	21	1	3.956	0.0467
Culturally sensitive services capacity	19	1	4.535	0.0332

Table 13B: Inner City Membership Representation and Language Capacity Cross-Tabulation

		Inner city membership representation		
		High	Low	Row total
Language capacity	High	7 / 33%	3 / 14%	10 / 48%
	Low	3 / 14%	8 / 38%	11 / 52%
	Column total	10 / 48%	11 / 52%	21 / 100%

Table 13C: Inner City Membership Representation and Culturally Sensitive Services Capacity Cross-Tabulation

		Inner city membership representation		
		High	Low	Row total
Culturally sensitive services capacity	High	7 / 37%	3 / 16%	10 / 53%
	Low	2 / 11%	7 / 37%	9 / 47%
	Column total	9 / 47%	10 / 53%	19 / 100%

- *Proportion of affiliated physicians practicing in primary care specialties:*

Based upon a median split of the distribution, organizations with a "high" proportion of primary care physicians were defined as those in which the self-reported proportion of primary care physicians was 40% or more. Organizations with 39% or fewer physicians in primary care specialties were defined as having a "low" proportion

of primary care physicians. The results of this analysis are presented in *Table 14A*. Associations were found between organizations with high proportions of primary care physicians and increased language services capacity (χ^2=4.915, p=0.0266) and increased culturally sensitive services capacity (χ^2=9.8282, p=0.0017). The latter showed a particularly strong association. The cross-tabulation results of these associations are provided in *Table 14B* and *Table 14C*.

Table 14A: Proportion of Physicians in Primary Care Specialties and Cultural Competency Capacities

Variable	n	DF	χ^2	p
Data availability capacity	27	1	0.425	0.5147
Community linkages capacity	19	1	1.611	0.2044
Language services capacity	22	1	4.915	0.0266
Culturally sensitive services capacity	19	1	9.828	0.0017

Table 14B: Proportion of Physicians in Primary Care Specialties and Language Capacity Cross-Tabulation

		Proportion of physicians in primary care		
		High	Low	Row total
	High	7	4	11
Language		32%	18%	50%
capacity	Low	2	9	11
		9%	41%	50%
	Column	9	13	22
	total	41%	59%	100%

Table 14C: Proportion of Physicians in Primary Care Specialties and Culturally Sensitive Services Capacity Cross-Tabulation

		Proportion of physicians in primary care		
		High	Low	Row total
	High	7	2	9
Culturally sensitive		37%	11%	47%
services capacity	Low	1	9	10
		5%	47%	53%
	Column	8	11	19
	total	42%	58%	100%

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- *Proportion of non-English speaking/non-English proficient (NES/NEP) members:*

Organizations which self-reported that 20% or more of their members were NES and/or NEP were classified into a "high" NES/NEP membership category, whereas those reporting that 19% or fewer members being NES and/or NEP were classified into a "low" category. The results of bivariate analysis are displayed in *Table 15*. Based upon the arbitrary definitions of "high" and "low" NES/NEP membership, there were no significant associations with cultural competency capacities demonstrated. Of some interest is the fact that language services capacity did not show an association with the proportion of NES/NEP members. This may, in part, be attributed to the arbitrary cut-off for "high" NES/NEP membership of 20% or more which was utilized (in order to establish a median split, dichotomous variable). For example, if a cut-off of 30% had been used instead, one would find that 5 out of the 6 organizations in this range of NES/NEP membership had language services capacity scores which were ranked as "high."

Table 15: Proportion of NES/NEP Members and Cultural Competency Capacities

Variable	n	DF	χ^2	p
Data availability capacity	33	1	1.530	0.2162
Community linkages capacity	20	1	0.840	0.3593
Language services capacity	23	1	1.066	0.3019
Culturally sensitive services capacity	20	1	0.220	0.6388

- *Proportion of Medi-Cal receiving members:*

Organizations with 20% or more of their members receiving Medi-Cal were classified into a "high" Medi-Cal membership category, whereas those indicating that either 0% or 1-19% of members received Medi-Cal were classified into a "low" category. This arbitrary cut-off of 20% did not result in an adequate median split distribution, with only 6 organizations being placed in the "high" category. This poor distribution of organizations is clearly a result of the inadequate percentage ranges provided in the questionnaire (more specifically, the range of 1-19% of membership receiving Medi-Cal,

which was the most commonly indicated response range among participants, had a degree of resolution which was obviously inadequate). As a result, interpretation of the following results should be tempered with some caution.

Bivariate analysis results are summarized in *Table 16*. As is evident in these results, those 6 organizations in which 20% or more members were Medi-Cal recipients had significantly higher scores in all four of the capacity areas examined (χ^2 of 7.192 to 10.123). All 6 of them received "high" rankings for each of the four capacities. This fact alone can account for the high measures of association, and therefore cross-tabulation results are not shown.

Table 16: Proportion of Medi-Cal Receiving Members and Cultural Competency Capacities

Variable	n	DF	χ^2	p
Data availability capacity	33	1	10.123	0.0015
Community linkages capacity	19	1	9.535	0.0020
Language services capacity	22	1	9.719	0.0018
Culturally sensitive services capacity	19	1	7.192	0.0073

- *Proportion of clinical sites in communities in which minorities comprise more than 50% of the population:*

Based upon a median split of the distribution, organizations with a "high" minority community service area were defined as those in which half or more clinical sites were located in communities in which minorities represented greater than 50% of the population served. Organizations with few or no clinical sites based in such communities were defined as having a "low" minority community service area. The results of this analysis are presented in *Table 17A*. Significant associations were found between organizations with high proportions of clinical sites in minority communities and increased levels of two capacities: language services capacity (χ^2=4.915, p=0.0266) and increased culturally sensitive services capacity (χ^2=8.202, p=0.0042). The latter showed an especially strong association. The cross-tabulation results of these associations are provided in *Table 17B* and *Table 17C*.

Table 17A: Localization of Clinical Sites in Minority Communities and Cultural Competency Capacities

Variable	n	DF	χ^2	p
Data availability capacity	22	1	2.288	0.1304
Community linkages capacity	20	1	3.452	0.0632
Language services capacity	22	1	4.915	0.0266
Culturally sensitive services capacity	20	1	8.202	0.0042

Table 17B: Localization of Clinical Sites in Minority Communities and Language Capacity Cross-Tabulation

		Proportion of sites in minority communities		
		High	Low	Row total
Language capacity	High	7	4	11
		32%	18%	50%
	Low	2	9	11
		9%	41%	50%
	Column total	9	13	22
		41%	59%	100%

Table 17C: Localization of Clinical Sites in Minority Communities and Culturally Sensitive Services Capacity Cross-Tabulation

		Proportion of sites in minority communities		
		High	Low	Row total
Culturally sensitive services capacity	High	7	3	10
		35%	15%	50%
	Low	1	9	10
		5%	45%	50%
	Column total	8	12	20
		40%	60%	100%

- *Perceived capacity to provide services to culturally and ethnically diverse populations and cultural competency capacities:*

One of the questions in the second section of the questionnaire asked the administrators surveyed to indicate the degree to which the felt their organizations were equipped to provide services for culturally and ethnically diverse populations. These responses were compared with the four observed scores of cultural competency capacity. Chi-square results and cross-tabulations are provided in *Tables 18A-18E*. As is evident in these results, there was a high degree of correlation between perceived

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capacities to provide services to culturally and ethnically diverse populations and each of the four observed cultural competency capacities (χ^2 of 12.131 to 15.090).

Table 18A: Perceived Capacity and Observed Cultural Competency Capacities

Variable	n	DF	χ^2	p
Data availability capacity	33	3	12.131	0.0069
Community linkages capacity	20	3	12.450	0.0060
Language services capacity	23	3	15.090	0.0017
Culturally sensitive services capacity	20	3	12.450	0.0060

Tables 18B-E: Perceived Capacity and Observed Capacities--Cross-Tabulations

Table 18B

		Perceived capacity to provide services to culturally and ethnically diverse populations				
		Inade-quately equipped	Moder-ately equipped	Well equipped	Except-ionally equipped	Row total
Data availability capacity	High	0	9	2	5	16
		0%	27%	6%	15%	48%
	Low	3	13	1	0	17
		9%	39%	3%	0%	52%
	Column total	3	22	3	5	33
		9%	67%	9%	15%	100%

Table 18C

		Perceived capacity to provide services to culturally and ethnically diverse populations				
		Inade-quately equipped	Moder-ately equipped	Well equipped	Except-ionally equipped	Row total
Community linkages capacity	High	0	4	1	5	10
		0%	20%	5%	25%	50%
	Low	2	8	0	0	10
		10%	40%	0%	0%	50%
	Column total	2	12	1	5	20
		10%	60%	5%	25%	100%

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Table 18D

Perceived capacity to provide services to culturally and ethnically diverse populations

		Inadequately equipped	Moderately equipped	Well equipped	Exceptionally equipped	Row total
Language services capacity	High	0	4	2	5	11
		0%	17%	9%	22%	48%
	Low	2	10	0	0	12
		9%	43%	0%	0%	52%
	Column total	2	14	2	5	23
		9%	61%	9%	22%	100%

Table 18E

Perceived capacity to provide services to culturally and ethnically diverse populations

		Inadequately equipped	Moderately equipped	Well equipped	Exceptionally equipped	Row total
Culturally sensitive services capacity	High	0	4	2	4	10
		0%	20%	10%	20%	50%
	Low	2	8	0	0	10
		10%	40%	0%	0%	50%
	Column total	2	12	2	4	20
		10%	60%	10%	20%	100%

Discussion:

In reviewing the results of the survey, discussion will focus on two general topics: 1) insights into problems and successes in design and methodology and 2) general principles and themes relating to cultural competency in California's managed care system which can be extracted from the responses provided by participants. It is the intention that this discussion not only provide foundations and recommendations for future research efforts in this area, but also offer perceptions which will be of value to policy-makers and health care administrators.

One motif encountered frequently in the analysis of the survey results is the significant quantity of missing data. The fact that the response rate of the study was somewhat less than had been aspired to initially has already been discussed, and is indeed the most problematic aspect of the entire survey. However, even within the

responding group there were prominent deficits of data in a number of important areas. While this fact has problematic implications for certain aspects of data interpretation and extrapolation, it can also be viewed in a more constructive light. In other words, missing data is a potential manifestation of a number of possibilities, all of which have relevance to future research and policy decisions in this area.

For example, in some cases, participants may not have provided responses to particular items for the simple fact that their organizations did not maintain the information requested in a readily accessible format. This proposition is supported by the fact that sections of the survey assessing the availability of data found many organizations conceding that such information was either unavailable or not reliable. If it is indeed the case that administrative mechanisms for assessing the various capacities involved in providing services to culturally diverse populations are lacking among managed health care organizations, a number of implications for future work arise. Further efforts in this area might, for instance, attempt to identify the specific barriers preventing administrators from assessing these capacities in managed care organizations. One potential structural barrier might, in fact, be misinformation. For example, one organization which did not provide data on the ethnic composition of its membership indicated that it was *illegal* for health care provider organizations to maintain such data. Alternatively, the inability of organizations to provide reliable data relating to their capacities to offer services in a culturally competent manner might be a reflection of a certain degree of administrative indifference to such issues. In either case, further research is necessary before effective interventions, policy or otherwise, for addressing this problem can proceed.

Another possible interpretation of the high proportion of missing data encountered in conducting the survey is that the survey instrument was flawed in its design. As was discussed in the section on instrument development, the questionnaire was pilot tested with public health and medical students, professional survey

instrument designers, health care administrators, and experts in the field of culturally competent health care provision. In the development of the survey instrument, every effort was made to utilize definitions and criteria of culturally competent care which could be administered to managed care organizations in a relatively universal manner. In addition, it was felt that the finalized questionnaire had sufficiently eliminated elements of language ambiguity while at the same time maintaining valid, widely applicable definitions of culturally competent health care policies and practices. Even so, certain aspects of survey implementation were not foreseen in the pilot testing or instrument development process. For example, the diversity of managed health care organization structures was perhaps not adequately anticipated. An assumption of many components of the questionnaire was that administrative respondents would have access to information on the clinical aspects of health care provision within their organizations. Based upon verbal and written responses from participants and non-participants, there is anecdotal evidence that this assumption may not have been appropriate for certain types of managed care organizations. In particular, a number of administrators indicated that some components of the questionnaire "did not apply" to their organizations because those organizations did not directly provide clinical services (such organizations were generically referred to in an earlier as "service brokers").

Given the possibility that organization structural factors may have been substantial variables influencing non-participation or failure to provide data, a range of important issues emerge. First, there is the considerable likelihood that significant organizational biases are present in the results of the survey. While respondent/non-respondent analysis did not reveal appreciable differences based upon two major structural variables (organization size and for profit/non-profit status), the eventuality that there was bias which ultimately led to the exclusion of organizations characterized by a variable or set of variables not identified in the analysis is a very real one. Unfortunately, this dilemma cannot presently be resolved.

A second issue which emerges in this area relates to the choice of assessment methodology. In retrospect, the decision to utilize a self-administered instrument and to survey high level administrators placed significant, intrinsic limitations on the validity and reliability of results. In part, this approach was taken out of necessity (for example, cost considerations were a major constraint in the design of the survey methodology). In addition, the decision to survey high level administrators was based largely upon the need to sample a population which would be relatively consistent throughout the wide range of managed care organization types. An alternative, more sophisticated approach to assessing the prevalence of culturally competent policies and practices among managed care organizations might utilize on-site inspections (for example, by trained raters) combined with qualitative methodologies of data acquisition. While such an approach would entail considerably more human and financial resources if it was conducted on a system-wide level, it would at the same time provide more reliable results.

The fact that some organizations were unable to provide any useful information on the availability of certain clinical services is relevant to a third issue which has policy implications. A central assumption of current work by the CCTF and other efforts to develop administrative guidelines for developing culturally competent health care systems is that accountability for the provision of culturally competent services will ultimately rest with administrators. Based on the above findings, such a supposition may not be entirely warranted.

To this point, the discussion has emphasized some of the major limitations of the survey, and has not promoted its more useful findings. The reader will recall that the primary goal of the project *Managing Care Across Cultures* was to provide descriptive information describing the prevalence and range of availability of culturally competent policies, practices, and structures among California's managed care organizations. In this regard, the project has been highly successful. Prior to this project, there were no

attempts to assess the penetration of largely academically constructed concepts of culturally competent care into the health care system at large. Hopefully, this project will be viewed as a useful starting point and possible prototype for future efforts in this area. While some of the results and relationships observed in the study may have considerable limitations regarding their generalizability to the managed care system as a whole, the survey reveals a number of general trends which have direct relevance to the future directions of research efforts and policy interventions in this area.

One of the most prominent findings of the survey is the striking variation in services and structures which exist from organization to organization. If *Managing Care Across Cultures* has accomplished nothing else, it has established that managed health care organizations in California extend along a broad spectrum with respect to their capacities to deliver health care in a culturally competent manner. While some participating organizations revealed considerable inadequacies in their resources for providing services in a manner consistent with present definitions of culturally competent care, others demonstrated broad utilization of culturally competent principles and practices. In addition, the results of the survey confirm the notion that health care organizations vary greatly with respect to the composition of the populations which they serve. For example, while many organizations served ethnically heterogeneous populations, others tended to serve more homogeneous niches with respect to ethnic diversity.

In addition to revealing differences between organizations, the study also identified a number of areas in which there are generalizable deficiencies among managed care organizations. Such broad inadequacies are significant to the development of future research and policy strategies. The unavailability of reliable data describing, for example, employee representation, membership demographics, and general service area demographics, appears to be a considerable problem for many health care administrators. Access to such data is critical for the adequate assessment

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of the specific issues of supply, demand, and need facing organizations that serve an increasingly culturally diverse population. Future research and policy efforts might consider incorporating approaches for making such data more readily accessible to managed care organizations. These efforts might also explore means of utilizing such data to more effectively adapt health care services to the populations being served.

As one of the only research endeavors to identify the penetration of culturally sensitive interventions into the health care system at large, the project also reveals some interesting trends which relate to the gulf between theories and practices of culturally competent care. For example, whereas culture broker, lay health worker, and indigenous health system interventions are discussed fairly extensively in academic health care related literature, utilization of such services among organizations surveyed was relatively uncommon. In contrast, there is evidence that some approaches discussed in the academic literature have been adopted by mainstream health organizations. For instance, the use of training programs and courses in cultural sensitivity have been adopted by a number of organizations.

The study also suggests that among organizations providing data, there are significant demographic predictors of the capacities of organizations to provide services in a culturally competent manner. Strong predictors of specific capacities included: a high proportion of clinical sites based in predominately minority communities, a high representation of inner city membership, a high proportion of Medi-Cal receiving members, a high proportion of physicians in primary care specialties, and non-profit status. While one must be wary in attempting to interpret such associations, the first three relationships provide some indication that organizations which tend to provide more culturally competent services appear to be reaching the populations most in need of such services. Of course, it is also acknowledged that such associations will require further study.

Among the most useful products of the *Managing Care Across Cultures* project are the results of the component obtaining attitudinal and knowledge level responses from administrators participating in the survey. The results of this section allow one to justifiably conclude that there is widespread and genuine interest among managed care organization administrators regarding the development of approaches which will make health care more accessible to cultural minority populations. For example, the overwhelming majority of administrators responding indicated that cultural factors contributed to significant barriers to obtaining health care, and that administrative efforts directed at overcoming these access barriers were a valid and important priority. All respondents felt that the goal of making health care organizations more culturally competent was a desirable one. Furthermore, a majority of respondents indicated that there was at least some necessity for efforts which would require health care provider organizations to pursue this goal. While genuine interest in issues of culture and health status was expressed among most participants, the study also found evidence which indicates that definitions of cultural competency have not been well established in this realm. Future efforts to develop policies relating to the issue of cultural competency in the health care system at large would be well advised to better articulate and disseminate such definitions.

In conclusion, the following specific recommendations are made for future research and policy efforts in this area. With respect to research, there continues to be a need to develop a reliable and valid instrument for assessing cultural competency at the level of the health care provider institution. As the experiences in the *Managing Care Across Cultures* project indicate, this is no small task. It is felt that the survey instrument developed in this project is highly useful with respect both to its utility as a quantitative device and to the validity of its included criteria and components. However, the problem of variation in health provider institutions regarding variables such as size and organizational structure must be addressed in future efforts to expand upon the

instrument. An on-site, third-party rater approach, incorporating both qualitative and quantitative methodologies, is also recommended for more objectively assessing the prevalence of culturally competent policies, practices, and structures among provider institutions.

This project examined cultural competency among health care provider institutions exclusively at the level of administration of entire managed care organizations. Future research should be directed at assessing the availability of culturally competent services and structures in other segments of the health care system, both public sector and private sector. An alternative unit of study, which would provide better resolution with respect to issues of local variation, is the community hospital or its equivalent. While performing a system-wide evaluation of individual hospitals would entail considerable resource expenditure, it would have the advantage of including broader sectors of the health care community, and might also avoid some of the problems of institutional structural variation faced with surveying managed care organizations at the level of administration. Such an approach could also begin to identify variations of culturally competent practices in specific clinical settings (for example, by exploring differences in service provision between in-patient and out-patient care). In fact, a project currently being undertaken by the National Public Health and Hospital Institute (NPHHI), the *Cross Cultural Competence Project*, has already developed a quantitative/qualitative, on-site visit instrument for assessing culturally competent practices at the level of the community hospital. Data from this regional project will be forthcoming in the near future.[287] While regional studies such as the NPHHI effort will provide valuable foundations for further work in this area, it is felt that future endeavors should also be ambitious with respect to scale. Presently, there is very little data on the availability of culturally competent services in the health care system at large (this in fact, was the primary motivation for the *Managing Care Across*

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[287]Personal correspondence with Carla McGregor, NPHHI (October, 1994).

Cultures project), and it is felt that future research must include statewide and nationwide studies.

Managing Care Across Cultures also identified some areas of future study through its preliminary assessment of bivariate relationships and its attempt to develop a quantifiable measure of culturally competent care at the administrative level. While the project was not successful in its goal of developing and validating an index of culturally competent care, it is felt that such an implement would be of great utility to further research in other segments of the health care system. Future research might seek to accomplish this goal by sampling a larger number of smaller health provider institutions (for example, through studying community hospitals or their equivalents, as discussed in the preceding paragraph). While it is acknowledged that the associations observed in the bivariate component of analysis are preliminary in nature, it is recommended that future research further examine such relationships. The further validation of such relationships would have particular significance to future policy interventions in this area--for example, in allowing such interventions to be directed more efficiently at segments of the health care system which tend to demonstrate less capacity to utilize culturally competent services and principles.

Another major area for further research is in the area of health care provider manpower, and the availability of health care practitioners who are representative of the particular ethnic and cultural minority groups which constitute patient populations. Historically, data availability in this area has been sparse, particularly regarding issues of minority health manpower supply and need in the private sector. An important principle of culturally competent care is that organizations be representative, in their employee structure, of the ethnic diversity of their service populations. While a regression analysis was performed on the data from the *Managing Care Across Cultures* project to elucidate relevant trends in this area, the results lacked statistical integrity and were not presented in the above analysis. However, research on such trends is

critical to developing a better understanding of the current cultural competency capacity of the health care system. Further research in this area should attempt to: 1) assess the availability of ethnic minority health manpower in the public and private sectors and 2) further explore the utility of patient-practitioner ethnic/culture-matching strategies.

One of the major problematic areas in the study of culturally competent health care continues to be the elusiveness of criterion based definitions of such care. The efforts of Richard Dana and colleagues at Portland State University, and now those of the CCTF, represent the only known efforts to rigorously accomplish this goal at the level of the institution. Indeed, one of the central arguments in the first three chapters of this paper has been the position that lack of consensus in this area has been highly counterproductive to recent research endeavors. Future research efforts should not only attempt to further validate criterion based definitions of culturally competent care, but should also examine components of such care which have perhaps not been as intensively studied by academic research. More specifically, as has been discussed in previous sections of this paper, definitions of culturally competent care are beginning to emerge from the private sector as well as the academic sphere. Future collaboration between such sectors is necessary for further research to be both pragmatic and generalizable to the health care system at large. While the pliability of the construct of culturally competent care has, from its inception, been one of its major pitfalls, it must also be viewed as its most redeeming strength. In order for concepts of culturally competent care to be applied in a broader array of health care contexts, a combination of rigor with respect to definitions of such care must be balanced with a flexibility to incorporate innovative approaches to such care.

Regarding the future development of policy interventions and strategies in this area, the following recommendations and conclusions are made. First and foremost, future policies must be guided by research conducted at a system-wide level (and should in fact incorporate such research in their design). Perhaps the most important goal of

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the *Managing Care Across Cultures* project was to provide baseline data on the prevalence of culturally competent services and principles among California's managed care organizations. Such data is essential to any intervention if an evaluation of its efficacy is to be conducted at some later point. In the future, it is advised that policies in this area also include means of assessing, in a quantitative manner, changes in the availability and utilization of services which result from those policies (particularly among underserved and ethnic/cultural minority groups). While it is often difficult to accomplishing this end in an entirely reliable manner (due to a variety of ecological factors which cannot be adequately controlled), the development of such indicators is critically necessary if the effectiveness of policy level interventions is to be demonstrated in a convincing manner.

It is also recommended that the development of future policy strategies in this area be cognizant of the great variation in capacities from organization to organization. Resources--whether written, human, or financial--must be made available to organizations to facilitate the development of culturally competent practices and procedures. In addition, time-tables and other logistical features of policies must consider such variation.

Policies should also consider structural barriers to their implementation. For example, the observation that a subset of managed care organizations are not involved directly in the provision of clinical services represents a prominent obstacle to future policies to develop culturally competent care in California's managed care system. Methods for developing administrative accountability in this case must be further explored if rational and meaningful policies are to emerge.

Policy-makers should also acknowledge that there is general receptivity to concepts of culturally competent care among health care administrators. This responsiveness should be considered a valuable resource in future policy efforts. For example, the successes of those organizations which have been particularly effective in

accomplishing goals of culturally competent care might be modeled for use by other organizations. Future policy decisions should be engaged in collaboratively with administrators, and should consider the real world constraints which are faced by such individuals.

In summary, *Managing Care Across Cultures* has been an effective example of an effort to create much needed bridges between the theory and the practice of culturally competent health care provision. Although many of the results of the project are preliminary in nature, and will require further verification and study, the effort has provided pragmatic data which will hopefully be of value to policy-makers, researchers, and health care administrators in the near future. With California's population rapidly diversifying, the need to develop and evaluate approaches for providing culturally competent services in a broader array of health care contexts is urgent. It is my greatest aspiration that the results of this endeavor will contribute to this process.

Conclusion

Is culture a barrier to health care?

Or is it an untapped ally which can be enlisted to improve access to health care?

Is it simply an audience to be marketed to?

Or is it a resource to be managed?

These certainly *are not* the questions which I started asking myself two-years ago. When I first set out on the meandering journey which has resulted in the creation of this thesis, my primary goal was to produce something of direct utility. More specifically, I wanted to generate data which would be quantifiable, tangible, and meaningful. In many respects, I feel that I have accomplished this goal.

However, in every good journey, it is inevitable that one will encounter a greater challenge which was not expected. As I proceeded to develop a survey which would assess the prevalence of cultural competency in California's health care system, I felt that I had a discrete, readily answerable question in hand. However, as I began to review more and more literature on the subject of cultural competency, a slight problem emerged: I could not figure out what it was. Now this was in no way a philosophical dilemma (any one who knows me will confirm that I am definitely *not* a philosophical person). I simply could not find a definition of cultural competency that reflected a satisfactory balance of both theoretical grounding and practicality. At first, I attempted to deny the existence of this dissonance. I continued to focus on the survey, convinced that I could shuffle away my dilemma by packing a brief review of literature on the subject of culturally competent health care into twenty pages or so.

As the reader has by now noticed, that twenty pages was not enough. Somewhere along the way, I realized that a review of the literature on the subject of cultural competency and health care could not be accomplished through a brief encapsulated summary. Furthermore, I decided that a relatively comprehensive review

of the historical, theoretical, and interventional sources of current concepts of culturally competent health care would likely be as useful as a survey attempting to assess the prevalence of culturally competent health care practices. A significant part of the impetus for this decision was my frustration with the lack of cohesion which is so characteristic of discussions on the topic of culturally competent health care.

In this paper, I have taken a critical approach in assessing the present state of theories and practices relating to cultural competency and health care delivery. I have attempted to explore the manner in which discourse on the topic of culturally competent health care is a powerful lens through which the micro- and macro-politics of the health care system can be better understood (in other words, I have viewed cultural competency as a socially constructed product of the medical community). I have provided examples of the counterproductive results of the competitive processes which have shaped many efforts to define cultural competency, such as redundancy of theories on the one hand and non-reproducibility of approaches on the other.

Cultural competency is a very large, elusive, umbrella of a concept. Some would argue that efforts to rigorously define it are futile. Theoretical definitions are almost invariably too ambiguous to be applicable in specific health care contexts. However, pragmatic definitions (which I will admit I tend to favor) are also subject to criticism on a number of fronts. For instance, when one attempts to define a concept based upon a set of interventions, the sticky business of establishing whether those interventions are efficacious (and how one goes about measuring that efficacy) is bound to emerge at some point.

A careful balance of theory and pragmatism may be the best approach available for defining the concept. To date, the work of Cross, et al. has been the most comprehensive effort to incorporate theories and interventions of culturally competent health care provision. Their strategy of disaggregating cultural competency into a variety of interventional levels, has also been an invaluable means for beginning to subdue the

concept into a manageable form. However, it is also important to acknowledge that substantial alterations in the application of cultural competency and related terminology have occurred since Cross, et al. published their groundbreaking work.

Because it has evolved as such a broad concept, with disturbingly fuzzy boundaries, cultural competency has been an easy target for bandwagoning by various sectors in the health care system. Perhaps bandwagoning is not an appropriate term, as it tends to carry a pejorative connotation. Nonetheless, it does strike at the heart of the phenomenon which has resulted in the explosion in the use of the term cultural competency in health care related literature in recent years. As cultural competency extends into health care disciplines which are fairly far removed from its original roots, dilemmas are now emerging which will potentially create further rifts between purists and pragmatists.

Even if it involves bending (and occasionally outright breaking) of the carefully thought out rules set forth by anthropologists in defining culture, I tend to favor a utilitarian course. If forced to take sides, I would argue that cultural competency is better seen as a vehicle than as a principle. Initially, cultural competency emerged as a focal point for uniting various theories aimed at improving health care delivery to cultural minority populations. The evolution of the concept reveals that it has perhaps lost some of its value in that regard. Nonetheless, it still has the potential to serve as a meeting ground for bringing together the various players in the health care system who have the power to make the system more accessible and compassionate to the needs of multicultural populations, whether those players be academicians, clinicians, policy-makers, or hospital executives.

Appendix A: Human Subjects Approval

Appendix B: Questionnaire, Cover Letter, and Consent Form

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