Cultural Competency Institute

The fourth annual Annie E. Casey Foundation (AECF) two-day conference was preceded this year by a one-day institute on cultural competence. The day began with AECF's Dr. Mareasa Isaacs, who led a discussion about the results of the cultural competence self-assessment tool completed by participants and analyzed before the Institute. A plenary discussion of some of those results followed. Finally, participants broke up into small groups to discuss cultural competency issues and conduct a self-assessment that helped participants understand their own cultural programming.

What is Cultural Competence?

Culture was defined as "the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies and practices of a particular group of people that provides them with a general design for living and patterns for interpreting reality. Culture determines how we see the world and the way we see the world is reflected in our behavior." **Competence** was defined as "having the capacity to function in a particular way; having the skills, knowledge and abilities to be effective; having a level of mastery."

Cultural competence was defined as "the awareness and appreciation of cultural differences and the knowledge, skills and abilities to translate these differences into appropriate attitudes and behaviors, thereby enhancing the capacity to respond effectively in cross-cultural settings and situations." Being culturally competent is a moral imperative for many. While the ideological argument may be persuasive enough, there are also very practical reasons for personally, and organizationally, becoming culturally competent.

For instance, demographics may demand it. What if your organization works with a population that speaks a different language from your staff? It may be more cost effective to train or hire staff that speaks that language—an investment with long-term returns rather than a repeated expense. As a result, cultural competence can help reduce health disparities among different populations, foster a more equitable distribution of resources and result in better outcomes.

Part I: Cultural Competence in Health Care: Analysis of Assessment Responses

Mareasa R. Isaacs, Annie E. Casey Foundation

Mareasa R. Isaacs is a senior associate for mental health at the Annie E. Casey Foundation in Baltimore, MD. She opened the pre-conference Institute with an address called "Cultural Competence in Health Care: Analysis of Assessment Responses." She derived revealing statistics from the self-assessment tool that participants had filled out prior to the conference.

The tool assessed an agency's cultural competence. Qualities of a culturally competent agency included:

- staff that reflects the client make-up
- culturally based supports and services
- no language barriers
- a location within the community that is easy to access
- hours and locations that are flexible
- services that are comprehensive
- commitment from leadership that is reliable
- outreach and prevention programs
- cultural competence goals, accompanied by the assessment tools to measure them
- coordination and collaboration across systems
- relationships with community leaders and other cultural brokers
- costs that are affordable and financing
- staff that is trained on an ongoing basis
- advocacy arm that promotes the well being of consumers and their communities

One of Dr. Isaac's main findings indicated a disconnection between the service providers and their target populations. A majority of agencies responding to the survey were better at identifying different groups than knowing the prevailing morals and customs of those groups. This disparity has had a ripple effect. Most agencies did not know much about home ownership and occupancy rates, crime and homicide rates, or even the birth and death rates within the communities the agencies said they served "well" or "very well." About half could describe the "strengths" of the community "well" or "very well." Only 36 percent did well or very well in recruiting a diverse staff that reflects the community.

To improve the cultural competence of an agency, Dr. Isaacs suggested making changes in specific areas. For instance, staff needs to be better trained, particularly when it comes to language ability. Those trained and experienced staff then need to be retained. Relationships with cultural brokers should be cultivated. Funding is often related to the ability to collaborate with others and coordinate services. Performance evaluation should take into consideration cultural competence, and it should cover both agencies and individuals.

Part II: Plenary Reactions to Aspects of the Self-Assessment Tool

In order to give participants a ground level perspective on cultural competence in community health centers, a group of four experts in the field gathered to present on their experiences in four areas related to cultural competence—youth, male health, mental health, and refugee health—and answer questions from the group. Each speaker was asked the following questions:

- In your professional experience working with your specialty, what obstacles has cultural competence created?
- In what ways have you used cultural competence and diversity to improve the work of your agency?
- In which directions do you plan to take cultural competence in the future?

Youth

A youth member of St. Thomas Health Services in New Orleans, LA, began the proceedings by reciting his touching and heartfelt poem about being fatherless as a young man and the impact it has had on his life.

Barbara Major, the Executive Director of St. Thomas Health Services, spoke about cultural competence in relation to youth health. A major obstacle to cultural competence is the way we each impose our world view on other people; often, the culture of the client is minimized. The reality is that youth have their own culture, language, even value system. Learning how to communicate with youth has been crucial for the staff of St. Thomas. Yet for all the ways that youth have their own culture, they still belong to a larger one composed of family, community, and country.

Though the staff works from and promotes an "anti-racist, culturally competent model" of social interaction, if it hopes to teach youth how to navigate systems such as schools and health services that might be hostile to them, it must also teach them how to organize to change those systems. It is not enough for youth to merely receive the services they need. They need to be self-determining people, engaged in their own needs, and those of the community at large.

Male Health

Arnold Perkins, the Director of the Alameda County Public Health Department in Oakland, CA, spoke about the need to be both clinically and culturally competent. Clinical competence is necessary for proper diagnosis; but cultural competence allows the practitioner to know what to look for. Knowing the right questions to ask of diverse populations is essential.

Mr. Perkins defined culture as "learned patterns of behavior." One example of how these patterns have played out among the clients at his agency is a resistance to prostate exams, which some men find threatening to their masculinity. Another is the confusion between "male," a genetic happenstance, and "man," a developed state. The agency trains young men to realize the difference by taking responsibility for things like their partner's pregnancy.

Cultural competence discussions concerning the role of men in different cultures would help health practitioners to make the right decisions concerning how to approach them and their treatment.

Mental Health

Maxwell Manning, Associate Professor of Social Work at Howard University School of Social Work, discussed how in our increasingly diverse society, cultural competence helps people function—talk to, work with, and live near others who are very different from themselves. Yet there is a fine line between "knowing" a culture and knowing it in a way that everyone from that culture is plugged into a readymade stereotype.

The stigma against mental illness in some communities of color needs to be understood to improve in diagnosis and treatment. Often family members of the mentally ill have been dealing with the issue for a long time, and their input is crucial.

In the community health setting, cultural competence is often a full-time issue that gets only part-time attention, even though it pervades every aspect of the environment.

One way to increase cultural competence is to understand that it is an issue relating not only to race or ethnicity, but also to class. Individual needs tend to supercede collective ones as a person advances economically. Retaining a sense of community and common purpose is more important than ever, as the gap in the United States between the haves and the have-nots threatens to become a chasm.

Cultural competence moves people from an ethnocentric viewpoint to an "enthno-relevant" one. One's own culture remains important, but it is seen in relation to others' cultures. What matters is the vitality of all.

Refugee Health

Johanna Price, a registered nurse and Health Literacy Advisor with the Refugee Women's Alliance in Seattle, WA, spoke about the relationship between cultural competence and social justice. Relying on stereotypes to inform one's notion of a culture short-circuits the reflection and thoughtfulness true cultural competence requires. How health practitioners view the people who use their services can relate to how they see society as a whole. Are users of services clients, customers, or patients? Are they ever students?

At the Refugee Women's Alliance, cultural competence is assessed by the clients, not the providers. The agency did this by hiring multilingual translators and family advocates from the community to interview clients on an ongoing basis.

Part III: Diversity Awareness Small Group Workshops

In the small group workshops, participants discussed their own experiences of feeling like outsiders in the past and discovered how their own cultural "software" influences the choices they make and the beliefs they hold. The goals of the workshop were to identify the impact of diversity on the participants' professional lives, understand the influence of each participant's cultural programming, and to build awareness that others have different cultural programming.

Feeling like an outsider is particularly distressing in a medical situation because our health may be at stake. Unfortunately, if you don't understand what is happening, a lot of your power and control is gone. Since none of us can ever really know what it's like to be in someone else's shoes, we must try to understand and empathize with another.

Diversity is the recognition or celebration of differences. It is an acknowledgment that around us is food, music, an accent or a clothing style that differs from our own. It doesn't necessarily demand interaction or participation on anyone's part.

Multiculturalism is an awareness of how those differences can create cohesion or friction, and it attempts to integrate those differences into a single system.

Pluralism results from having many unique characteristics playing off one another within one system. Families generally function in a pluralistic fashion, making exceptions and allowances for various strengths and weaknesses. Pluralism is the goal of a willingly heterogeneous society because it then can pull from its myriad resources. The whole becomes greater than the sum of its parts.

A health care organization is made up of leaders and staff members that directly influence its cultural competence. Your mores and beliefs about yourself, your background, your community and society at large heavily influence how your health services are delivered. These are your cultural hardware and software, which often influence your actions and thoughts.

To practice consensus building and discover which characteristics are considered integral to cultural competency, participants were asked to rank 10 behaviors of a health care employee. These qualities are often seen in effective health care organizations.

While there were variations (see Worksheet A at end of Tool), several behaviors were common to all groups. For example, everyone agreed that:

- a health care employee should be flexible and creative in finding alternative ways to communicate with clients if there is a cultural barrier;
- treating all clients with respect and dignity was extremely important;
- personal pride helps patients feel secure; and
- understanding the different cultural norms and preferences of clients and co-workers is needed.

Each individual brought a specific and unique set of experiences and beliefs to the table. Those experiences and beliefs were looked at next in the workshop. Can we alter how we interpret our experiences? Are those beliefs "hardwired"? To explore those questions, the participants discussed cultural "hardware" and "software."

Cultural Hardware and Cultural Software

Cultural hardware comprises everything about ourselves that we cannot change: our genes, our physical components—heart, lungs and brain, for instance. Hardware is fixed, and we cannot live without it. Cultural software is the malleable and programmable input we get from our environment: family, friends, school, country, language, religion. Mannerisms, feelings, beliefs, values and preferences are all software. Software is learned behavior.

In one of the workshops, Frank Beadle de Palomo, the Vice President and Director of the AED Center for Community-Based Health Strategies, gave an example from his own life.

Hardware: He has brown eyes.

Software: His grandmother told him if he ate his bread crust he'd get blue eyes.

Software: His desire to have blue eyes.

The beliefs and norms people learned throughout their lives can be positive as well as negative. To explore how these beliefs and norms developed, the participants were given a worksheet and asked to identify the most important influences on their beliefs and values. It helped them to identify the sources of software, which values, norms or beliefs that they hold derive from those sources and how those beliefs have had an impact on their lives and work.

The worksheet participants used for this exercise is attached at the end of this Tool as Worksheet B. You can use this worksheet at your agency to analyze and understand the cultural hardware and software of your staff.

This tool was prepared by the AED Center for Community-Based Health Strategies from the 2002 Annie E. Casey Community Health Summit.

Directions for Using Behaviors of an Effective Health Care Employee in a Pluralistic Environment Worksheet (Worksheet A)

Objectives

- To stimulate discussion about essential behaviors necessary for employees on a cross-cultural environment.
- To define some clear behaviors that managers can teach their staff members.

Intended Audience

- Managers helping coach, groom, or teach employees to be more effective in a cross-cultural environment.
- Trainers, consultants, and HR professionals who work with health care staff.
- High-achieving employees who would like the chance to manage and supervise others.
- Staff who serve diverse patient groups.

Time

60 minutes

Suggested Procedures

Begin by explaining that the health care employee of today who works in a diverse environment needs a refined set of skills different from those of a manager or employee who worked in a homogeneous environment years ago.

Ask participants to form groups of approximately seven participants each and tell each group where to sit.

Once groups have formed, hand out the worksheets and explain that each person is to read all ten behaviors that are listed and determine their order of importance from his or her viewpoint, with 1 being the most and 10 being the least important.

After they have had time to think of their rankings, tell people to record their answers in the "Individual Ranking" column.

Tell groups to discuss their individual rankings with other members of their group, with the goal of reaching consensus on the order. Tell them to record their group answers in the column marked "Group Ranking."

At this point, you may want to provide some guidance for achieving consensus in the activity:

- Consensus is defined as "something we can support for at least some period of time."
- Each person is responsible for presenting his or her own viewpoint, but not arguing it.
- There should be no voting.
- Keep focusing on common ground and working towards agreement.
- Give the groups approximately 30 minutes to discuss the items and reach consensus.
- Draw a grid on the newsprint pad to record the rankings of all the groups and to compare their responses.
- Lead a large group discussion focused on the underlying values of each choice, the range of differences, the strength of people's beliefs, and the ability to be open-minded and able to change. Possible discussion questions could include:
    - What was your reaction to participating to this exercise?
    - What principals or values guided your choices? Share some of the discussion points that influenced the ranking within your group.
    - What health care behaviors might be added to or subtracted from this list if you were in a more homogeneous environment?
    - Did people change their minds during the small group discussions? If so, what made that possible? What are the implications of an openness to change on a daily basis?

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Directions for the Analyzing Your Own Cultural "Software" Activity (Worksheet B)

Objectives

- To increase understanding of the influence of one's own cultural programming.
- To build awareness that others have different cultural programming.
- To build common ground with co-workers of different backgrounds.

Intended Audience

- Participants in diversity awareness trainings.
- Members of diverse work groups.

- Managers of diverse teams of departments.
- Staff serving diverse patients and family members.

Time

45 to 60 minutes

Suggested Procedures

- Give a short lecture explaining that culture is like a software program that directs our behavior, using a few examples to illustrate the point (from the previous tool as well as your own life).
- Ask participants to brainstorm sources of their own software, charting participants' responses, as well as the values or norms learned from each source, on newsprint.
- Have participants delineate their own software influences by filling out the worksheet.
- Explain that participants will be sharing their responses with another individual in the next phase of the activity.
- Tell participants to pair up, preferable with someone they do not know well and who is different from them on some diversity dimension. Tell them to share information with their partners about the development of their own cultural software and its impact on their lives.
- Lead a large group discussion focusing on insights and applications. Possible discussion questions include:
  - — What similarities and differences were there in your software programs?
  - — Were there any surprises?
  - — What were the most important influences on your beliefs and values?
  - — How do these beliefs and values impact your work?

Please note: Because this activity requires a look into the past, it may dredge up some painful memories or experiences. Let participants know ahead of time that they will be asked to share information about this. Also, explain that not all influences are positive and that negative ones play a role in the development of our software.

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Behaviors of an Effective Health Care Employee in a Pluralistic Environment

Directions: Rank order your responses from 1 to 10, 1 being the most important behavior for a health care employee. Then reach consensus as a group on the order of importance from 1 to 10.

Your Ranking	Behavior	Group Ranking
	Works through religious and various community groups to create ties to the community.	
	Understands the different cultural norms and preferences of patients and co-workers.	
	Takes the initiative to offer information to make patients feel comfortable.	
	Is flexible and creative in finding alternate ways of informing and communicating with patients and families.	
	Cultivates productive relationships with fellow employees.	
	Treats all patients and family members with dignity and respect.	
	Gives necessary information in ways that people of various backgrounds and education levels can understand.	
	Knows how to work within the system to make the process as user friendly as possible.	
	Takes pride in helping patients feel secure.	
	Solicits and uses feedback to improve interactions with patients and families.	

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Analyzing Your Own Cultural "Software"

Directions: Think of the most important influences on the development of your individual cultural "software" program. Using those already listed that pertain and adding others, list the most significant values, norms, rules, and beliefs you have adopted from each source. Then indicate what impact each has made on your life and work.

For example, if your parents taught you the value of a strong work ethic, does that make you a responsible and conscientious employee? Does it also make you impatient with co-workers who don't work as hard as you?

Source	Values, Rules, Norms, Beliefs Adopted	Impact on Life and Work
Family		
Parents		
Siblings		
Grandparents		
Extended family		
Spouse		
Children		
Geographic Location		
Country		
Neighborhood		
Childhood		
Present residence		
Religion		
Early years		
Currently		
Education		
School		
College/University		
Continuing		
Friends		
Childhood		
Current		
Colleagues/co-workers		
Professional Life		
Field of work		

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