



Original Article:

Continuing Education Effects on Cultural Competence Knowledge and Skills Building among Health Professionals

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Abstract: Racial and ethnic minority health data from a national perspective indicates there is much to learn in the public health workforce about the ongoing health disparities crisis. This suggests a level of urgency to assist our public health professionals in obtaining specific skills sets that will assist them in working better with vulnerable populations. The purpose of this research is to assess cultural competence knowledge and programmatic skill sets, utilizing an explorational case study, of individuals employed within an urban public health department. In order to effectively evaluate these constructs, a quantitative research approach was employed to examine participants' knowledge and competencies of the subject matter. This data was further analyzed to determine if continuing education participation and training was correlated to the levels of culturally competent practice engagement and self-reported confidence. In addition, researchers obtained data on the availability of employer sponsored training opportunities. The data suggested when health professionals engage in cultural competence education, their level of awareness of unique characteristics between ethnic and racial minorities increased. Those who exhibited the healthiest behaviors, as it relates to effectively working with diverse populations, had a heightened sense of knowledge related to culture and healthcare services. Continuing education in cultural competence is an essential strategy for improving public health employees' effectiveness in working with diverse clients and reducing racial and ethnic health disparities. As the finding illustrated, training programs must incorporate educational components which foster skill building to enable subsequent culturally appropriate clinical interactions.

Key Words: Continuing education; Cultural competence; Skills building; Workforce development; Clinical interaction; Quality of care.

Introduction:

Racial and ethnic minority health data from a national perspective indicates there is much to learn in the public

health workforce about the ongoing health disparities crisis. This suggests a level of urgency to assist our public health professionals in obtaining specific skills sets that will assist them in working better with ethnic and racial minority populations. These skills encompass culturally competent care and entails understanding the social and cultural factors which influence individual health beliefs and behaviors.¹ Heightened levels of cultural competence by public health workers enable the elimination of health disparities. This concept is well accepted and incorporated into many initiatives of federal organizations, such as the National Institutes of Health and the Agency for Healthcare Research and Quality.²

The concept of cultural competency focused continuing education for the public health workforce is stressed within the National Standards on Culturally and Linguistically Appropriate Services (CLAS). The activities and principles are designed to be integrated not only throughout health care organizations and across professional disciplines, but implemented as a partnership with the served communities (Office of Minority Health & Health Disparities, 2007). There are organized themes comprised from 14 standards: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). The three types of standards are: 1) CLAS mandates; current Federal requirements for all recipients of Federal funds (Standards 4-7); 2) CLAS guidelines; activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1- 3, 8-13); and 3) CLAS recommendations; suggested by OMHD for voluntary adoption by health care organizations (Standard 14).³

Public health providers may influence race, ethnicity and socioeconomic health disparities in numerous areas. Providers may reflect and/or reinforce societal notions regarding patients' own value, self-reliance, knowledge, and

deservingness of effective care.⁴ In addition, providers have the ability to communicate lower expectations for patients in disadvantaged social and economic positions.⁴ This is an example of the public health workforce's influence on individual's expectations for the degree to which they expect to obtain the resources and services they need, and their expectations for improvements in their conditions and situations. Also noted is patients' health related cognition and behavior being highly correlated to provider communication.⁴ In addition, health care professionals act as gatekeepers, differential access to services and treatments, as well as benefits, are well documented. All these factors, whether intentional or unintentional, may account for some of the disparities observed in health outcomes.⁴

Continuing education in cultural competence is an essential strategy for improving public health employees' effectiveness in working with diverse clients and reducing racial and ethnic health disparities. An extensive literature review identified studies which evaluated interventions designed to improve cultural competence of health professionals. It is reported most studies illustrated beneficial effects on participant knowledge.⁵ The areas of intervention were broad including culture-specific knowledge (e.g., cultural traditions, norms) and adverse health outcomes as a result of provider bias.⁵ In addition, findings suggested skills building training among health care professionals improves their interactions with patients. In one study, participants were given various hour sessions to practice communication skills with community members. As a result, participants were more competent in interviewing a non-English-speaking person.⁵ Other observed behaviors included an increase in nurses' involvement in community-based chronic disease education programs, learners reported increased social interactions with peers of a different race/ethnicity, and an improvement in their ability to conduct a behavioral analysis and treatment plan.⁵

An evaluation of the effectiveness and acceptability of antiracism and cultural competence training among health care professionals providing services to children was conducted by a team of researchers. The curriculum was designed to give learners the opportunity to gain an understanding of how racism and personal views hinder the delivery of services.⁶ This was conducted through small multidisciplinary group discussion, with strict ground rules, facilitated by antidiscrimination professionals.⁶ A retrospective evaluation was conducted with trainees to identify their views between two and seven years upon course completion. Seventy-five percent gave positive reviews to one or more of the questions related to behavioral change and; practice and communication modification.⁶

The Society of General Internal Medicine Health Disparities Task Force used a review process for the development of recommendations and guidelines of health disparities curricula for staff employed in clinical settings. The taskforce provides learning objectives, curriculum content, teaching methods and implementation resources.⁷ Recommendations suggest curricula address three areas of racial and ethnic health disparities and focus on specific learning objectives. These include examining and understanding patients' attitudes, such as mistrust, subconscious bias, and stereotyping, which can impact clinical encounters. Also, trainees should gain knowledge focused on the existence and magnitude of health disparities, including the causes and subsequent solutions of health disparities, in an effort to diminish or eliminate them.⁷ The final objective encompasses skills building to effectively communicate and negotiate across the diverse cultural, linguistic and educational levels of patients. The overall goal of the curriculum is to assist learners in developing a personal commitment to eliminating inequities in health care quality.⁷

It has been suggested that culturally competent practice in health care settings, requires organizational commitment and the development of infrastructure to promote and support employee diversity, and responsiveness to cross-cultural issues.⁸ Specifically, interventions must include exploring ways to achieve multidimensionality in training programs. Researchers have identified Donabedian's model as a useful framework to assess proposed institutional changes to promote and support culturally competent practice.⁸ The model examines outcomes from clinical/administrative standards, through environmental characteristics and resourcefulness. It seeks to identify strategies to improve health care services and patients' satisfaction. Some areas of inquiry include the adoption of multifaceted, strategic culturally competent care by senior management and organizational boards; the managerial support and accountability for the implementation of employee training programs; and the strategic integration of cultural competency principles and values into ongoing service delivery.⁸

The purpose of this research is to assess cultural competence knowledge and programmatic skill sets, utilizing an explorational case study, of individuals employed within an urban public health department. In order to effectively evaluate these constructs, a quantitative research approach was employed to examine participants' knowledge and competencies of the subject matter. This data was further analyzed to determine if continuing education participation and training were correlated to the levels of culturally competent practice engagement and self-reported confidence. In addition, researchers obtained data on the availability of employer sponsored training opportunities.

Methods

Sample

Within the study design, participants were identified using convenience sampling. Employees (n=90) from four metropolitan clinical sites of an urban public health department located in the southwest region of the United States were solicited and recruited during a monthly staff meeting. This sample is representative of 84% of the total employees which is comprised of 107 individuals. Participants met criteria for inclusion in the study if they: 1) work in a clinical setting and 2) provide services to individuals of racial and ethnic minority backgrounds. Participants included nurses, physicians, and oral health practitioners, as well as general medical and clerical staff. For reporting purposes, participants were divided into subgroups, clinical and non-clinical (e.g., clerical staff). This was completed to account for the variation in respondents' level of education, type of client/patient interaction and opportunities for professional development engagement.

Measurement

All concepts were measured using an ordinal scale. Descriptive statistics characterized healthcare professionals' cultural competence and personal demographic measures. Prior to analysis, negative items on the attitude measure were reverse coded so a higher score indicated a more favorable attitude. One-way analysis variance (ANOVA) was used to compare knowledge, behavior and culturally sensitive attitudes (CSA) across race, and educational level. In order to evaluate equality between knowledge, behavior and CSA scores across diversity training participation, a T-Test was employed. Associations between knowledge, behavior and CSA scores; and race, diversity training and educational levels were determined by Fisher's Exact Test.

Theory

The derivative of the dissertation design can be attributed to the Theory of Planned Behavior (TPB) developed by Martin Fishbein and Icek Ajzen, which evaluates the correlation between behavior and beliefs, attitudes and intention, of an

individual, as well as their level of perceived control.⁹ There are four constructs incorporated within this the TPB framework. These include behavioral intent, attitude, subjective norm and perceived behavioral control. TPB suggests that deliberate individual behavior is driven by behavioral intentions and is a function of an individual's attitude toward the behavior, the subjective norms surrounding the performance of the behavior, and the person's perception of the feasibility in which the behavior can be performed.¹⁰

Within the theory, attitude toward the behavior is described as the individual's positive or negative feelings about performing a behavior. It is determined through an assessment of one's beliefs regarding the consequences arising from a behavior and an evaluation of the desirability of these consequences.¹⁰ Subjective norm is an individual's perception of whether key people believe the behavior should be performed. Behavioral control is defined as one's perception of the difficulty in performing a behavior. TPB suggests control that people have over their behavior as being continual. However, the behaviors are easily adopted only if effort and resources merge.¹⁰ The TPB takes into account that all behavior is not under volitional control and behaviors are located at some point along a continuum extending from total control to a complete lack of control. Control factors include both internal factors and external factors.¹⁴

The goal of TPB is to not only predict but also explain human behavior. The theory suggests behavior is a function of salient beliefs relevant to specific behaviors. These beliefs are considered the determinants of an individual's intentions and actions.¹¹ These salient beliefs include: behavioral beliefs, normative beliefs and control beliefs. Behavioral beliefs influence attitudes toward the behavior. Normative beliefs are the underlying components of subjective norms; and control beliefs provide the foundation for perception of behavioral control.¹¹

Literature is limited in the study of TPB being applied to the public health workforce to understand and modify behavior.¹² However, possible predictions for this research include:

- 1) If organizational culture promotes and values cultural competence and health disparities capacity building, then employees are more likely to participate in diversity training and continuing education.
- 2) If public health employees are provided with cultural competence and health disparities training, then they have a heightened sense of behavioral control in implementing effective clinical encounters.

Assessment Tool

The *Cultural Competence Assessment (CCA)* is designed to explore individual knowledge, feelings and actions of respondents when interacting with others in health service environments.¹³ The instrument is based on the cultural competence model, and measures cultural awareness and sensitivity; cultural competence behaviors and cultural diversity experience and training on a 49 item scale. It seeks to assess actual behaviors through a self-report, rather than self-efficacy of performing potential behaviors.¹⁴

Cultural awareness and sensitivity is analyzed with the Cultural Awareness and Sensitivity (CAS) subscale which measures with a 5-point likert-like response. The CAS scale was divided in two sections, *knowledge* and *culturally sensitive attitudes*. An assessment of cultural competence behaviors is measured by the Cultural Competence Behaviors (CCB) subscale, with response categories of always, often, at times, never, and not sure.¹⁴ A single-item index is used for cultural diversity experience with respondents being asked about the amount of various encounters with minority groups within the past year. Subscale scores are provided by adding the CAS and CCB totals.¹⁴ Higher scores indicate more

positive attitudes, a higher level of knowledge and increased engagement of competence behaviors. In addition, CCA assesses self-identified ethnic/racial group, age and education.¹⁴

A convenience sample of 405 healthcare providers were recruited from hospitals, home health agencies and community health agencies, to research CCA reliability and validity among the populations. Content and face validity for the instrument was established and the internal consistency was documented at .92. Cronbach's alphas for CAS and CCB subscales were reported at .75 and .93, respectively.¹⁵ The psychometric analysis of CCA suggests it is an effective tool to measure cultural competence. It is useful in evaluating healthcare professionals' specific cultural competence training needs which may decrease health disparities.¹⁵

Researchers have also utilized the Cultural Competence Behaviors (CCB) subscale tool to determine if there is an association between cultural competence of primary care providers and the clinics in which they are employed. Forty-nine providers, from twenty-three clinics responded to the online survey, across two states.¹⁶ The data suggested providers who possess attitudes which reflect increased cultural learning motivation, are more likely to work in clinics which offer diversity training and cultural competent patient education materials.¹⁶ An examination of cultural competence of thirty-one public health nurses with CCA, concluded participation in specific types of training was highly correlated to cultural competence knowledge and attitudes.¹⁶ Many reported increased levels of cultural competence knowledge and beliefs; however they disclosed the need for diversity education opportunities, to enable favorable clinical application.¹⁶

Results

Knowledge scores were determined through the analysis of specific questions pertaining to the cultural competence survey tool (see Figure 1). Within the non-clinical group, using the Pearson Correlation Coefficients formula, a positive correlation was found between respondents' knowledge score and diversity training. In addition, non-clinical staff that participated in diversity training in the past had a significantly higher mean knowledge score than their counterparts who had not undergone training. This suggests if healthcare professionals engage in cultural competence education their level of awareness of unique characteristics between ethnic and racial minorities increase.

Figure 1: Items examined for knowledge score	
Criteria Examined	
Race is the most important factor in determining a person's culture.	
People with a common cultural background think and act alike.	
Many aspects of culture influence health and health care.	
Aspects of cultural diversity need to be assessed for each individual, group, and organization.	
If I know about a person's culture, I don't need to assess their personal preferences for health services.	
Spiritually and religious beliefs are important aspects of many cultural groups.	
Individual people may identify with more than one cultural group.	
Language barriers are the only difficulties for recent immigrants to the United States.	

The cultural competent behavior (CCB) score is determined through the analysis of items of the survey tool (see Figure 2). Within the non-clinical subgroup, the data analysis confirmed a statistically significant positive association between knowledge score and average CCB score. This

allowed researchers to conclude those who exhibit the healthiest behaviors as it relates to effectively working with diverse populations, had a heightened sense of knowledge related to race/ethnicity and healthcare services.

Figure 2: Items examined for cultural competency behavior (CCB) subscale
Criteria Examined
I include cultural assessments when I do individual or organizational evaluations.
I seek information on cultural needs when I identify new people in my work or school.
I have resource books and other materials available to help me learn about people from different cultures.
I use a variety of sources to learn about the cultural heritage of other people.
I ask people to tell me about their own explanations of health and illness.
I ask people to tell me about their expectations for health services.
I avoid using generalizations to stereotype groups of people.
I recognize potential barriers to service that might be encountered by different people.
I remove obstacles for people of different cultures when I identify barriers to services.
I remove obstacles for people of different cultures when people identify barriers to me.
I welcome feedback from clients about how I relate to people from different cultures.
I find ways to adapt my services to individual and group cultural preferences.
I document cultural assessments if I provide direct client services.
I document the adaptations I make with clients if I provide direct client services.

There were no significant differences found in mean scores of knowledge or behavior across race/ethnicity among clinical or non-clinical respondents. However, across all races and ethnicity categories, clinical respondents had higher average knowledge scores compared to their non-clinical peers (see Table 1). Analysis of engagement of culturally appropriate behavior activity determined non-clinical Hispanics/Latinos and whites engaged in behaviors more conducive to healthier outcomes for patients, compared to their clinical counterparts (see Table 2).

Table 1: Knowledge score averages by race/ethnicity		
Race/Ethnicity	Knowledge Score (mean)	
	Clinical (SD=0.90)	Non-clinical (SD=0.84)
Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)	3.585	3.438
White/Caucasian/European American	3.958	3.313
Black/African American/Negro	3.431	3.301
Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)	3.125	n/a
Other	4.250	n/a

C (F=(5,52)=1.64, p>.05) ; NC (F=(3,25)=.08, p>.05)

Table 2. Behavior score averages by race/ethnicity		
Race/Ethnicity	Behavior Score (mean)	
	Clinical (SD=1.36)	Non-clinical (SD=1.37)
Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)	3.578	4.299
White/Caucasian/European American	3.929	4.548
Black/African American/Negro	3.861	3.841
Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)	2.214	n/a
Other	4.461	n/a

C (F=(5,52)=0.54, p>.05) ; NC (F=(3, 25)=0.45, p>.05)

Clinical diploma recipients had increased knowledge levels compared to their non-clinical counterparts. However, non-clinical individuals with a high school diploma were more knowledgeable than clinical peers. Non-clinical respondents with an Associate's degree as their highest level of education had a higher mean knowledge score than their clinical peers. In addition, clinicians with graduate or professional degrees had a heightened level of knowledge compared to their non-clinical peers (see Table 3). The same analysis suggested non-clinical respondents within the diploma and high school, Associate and Bachelor's degrees levels of education engaged in more culturally appropriate behaviors than clinical counterpart workers (see Table 4).

Table 3: Knowledge score averages by education		
Highest Level of Education Completed	Knowledge Score (mean)	
	Clinical (SD=0.90)	Non-clinical (SD=0.84)
Less than high school	3.750	n/a
Diploma	3.765	2.892
High School or GED	3.241	3.567
Associate degree	3.761	3.937
Bachelors degree	3.732	3.750
Graduate or Professional degree	3.465	2.687

C (F=(6,46)=0.58, p>.05) ; NC (F=(5, 22)=1.84, p>.05)

Table 4: Behavior score averages by education		
Highest Level of Education Completed	Behavior Score (mean)	
	Clinical (SD=1.36)	Non-clinical (SD=1.37)
Less than high school	5.28	n/a
Diploma	4.160	4.351
High School or GED	3.697	4.040
Associate degree	3.900	4.827
Bachelors degree	3.657	4.964
Graduate or Professional degree	2.944	2.535

C (F=(6,46)=1.20, p>.05) ; NC (F=(5, 22)=1.23, p>.05)

Discussion

Life expectancy and overall health have improved in recent years for most Americans, thanks in part to an increased focus on preventive medicine and dynamic new advances in medical technology. However, not all Americans are benefiting equally. For too many racial and ethnic minorities in the United States, good health is elusive, since appropriate care is often associated with an individual's economic status, race, and gender. Despite notable progress in the overall health of the nation, there are continuing disparities in the burden of illness and death experienced by Blacks or African Americans, Hispanics or Latinos, American Indians and Alaska Natives, and Native Hawaiian and other Pacific Islanders, compared to the U.S. population as a whole.¹⁷

We have a need to assist our public health professionals in obtaining specific skills sets and competencies that will enable them to work better with ethnic and racial minority populations. These skills encompass culturally competent and appropriate; and entails understanding the social and cultural factors which influence individual health beliefs and behaviors.¹ Public health providers may influence race/ethnicity and socioeconomic health disparities in numerous areas, by reflecting and/or reinforcing societal notions regarding patients' own value, self-reliance, knowledge, and deservingness of effective care.⁴ In addition, providers have the ability to communicate lower expectations for patients in disadvantaged social and economic positions.⁴ This is an example of the public health workforce's influence on individual's expectations for the degree to which they expect to obtain the resources and services they need, and their expectations for improvements in their conditions and situations.

Research suggests cultural educational preparation and knowledge subsequently influences healthcare professionals' skills in interacting with ethnic and racial minority patients. Employees with the most confidence in their cultural relational working skills had high levels of confidence in their knowledge of cultural concepts.⁵ Continuing education in cultural competence is an essential strategy for improving public health employees' effectiveness in working with diverse clients and reducing racial and ethnic health disparities. Assessments concluded interventions designed to improve cultural competence of health professionals illustrated beneficial effects on participant knowledge and self-efficacy.

The results of this research highlight respondents with past diversity training as having a higher level of culturally competent knowledge when interacting with clients and patients. In turn, their knowledge and awareness led to them engaging in behaviors conducive to improving racial/ethnic health outcomes. Training programs must incorporate educational components which foster skill building to enable subsequent culturally appropriate clinical interactions. In addition, non-clinical diploma recipients displayed a higher level of culturally competent behavior engagement than their clinical peers. This suggests future research can be employed to determine if there are positive effects of using this population as gatekeepers for the improvement of patient-provider interaction.

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