

Cultural Competence in Primary Health Care in Public Health Settings

A Report from the Wright State University School of Professional Psychology Ellis Human Development Institute

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Overview

The Health Foundation of Greater Cincinnati awarded a grant in 1999 to assess cultural competence in community-based primary healthcare settings. The project included:

- demographic projections of the population composition in the Health Foundation's 20-county service area,
- the expected impact of demographic changes on the service environment of primary healthcare providers,
- a regional survey of providers and patients on current practices and policies that incorporate cultural considerations, and
- a literature review of best practices.

The aim of this assessment was to increase the capacity of providers to improve health encounters and outcomes for ethnically, culturally, and linguistically diverse patients. The data gathered in this project suggest that the region will face significant challenges in providing an adequate level of culturally competent services.

Demographic Projections

Between 1990 and 2005, the Greater Cincinnati region's total population is projected to increase by 11.8%. In all counties, the growth rate for racial or ethnic groups will far exceed that of the white non-Hispanic population. In Hamilton County, the proportion of the white non-Hispanic population is expected to decline by 12.6%. This shrinkage, in combination with higher growth rates among non-white groups in 2005, will result in white non-Hispanics comprising 73.1% of the Hamilton County population—falling below 75% for the first time in the county's history.

In the region's four largest counties (Butler and Hamilton Counties in Ohio and Campbell and Kenton Counties in Kentucky), growth in non-white populations will occur at a somewhat slower pace than in the other 16 counties, where Asian American and Hispanic populations will be at or close to double their present size by 2005. In Boone County, Kentucky, the Asian American and Hispanic populations are projected to triple in that time.

In the Midwest, “diversity” has historically meant African American, with only a small representation of other ethnic groups. In addition, diversity has been largely confined to descriptions of urban centers. In the future, the largest numbers of non-white individuals will still be found in large cities. African Americans will continue to be the largest non-white population in the region. However, the emerging picture suggests that in the next decade there will be:

- increased numbers of Asian American, Hispanic, and Native American residents;
- slower growth rates for the white, non-Hispanic population;
- increased diversity in rural and suburban areas; and
- significant increases in limited-English or non-English-speaking populations.

Increases in certain populations are already being seen. In addition to greater numbers of Hispanic and Asian American patients, Greater Cincinnati area providers reported serving a greater number of people from other racial or ethnic groups, such as West African, Russian, Bosnian, and Middle Eastern groups.

It is an unfortunate fact of American society that racial and ethnic groups are overrepresented in the low-income population. Therefore, the primary care safety network in our region will most likely become a major provider to ethnically and linguistically diverse patients. In the coming years, it will be critically important for these providers to develop their abilities to serve these populations effectively.

Regional Survey

The purpose of the regional survey was to gather information from healthcare providers, health agency administrators, and patients on their perceptions of current policies and practices related to cultural competence. The survey consisted of telephone interviews with healthcare providers and administrators and in-person interviews with patients at area health clinics.

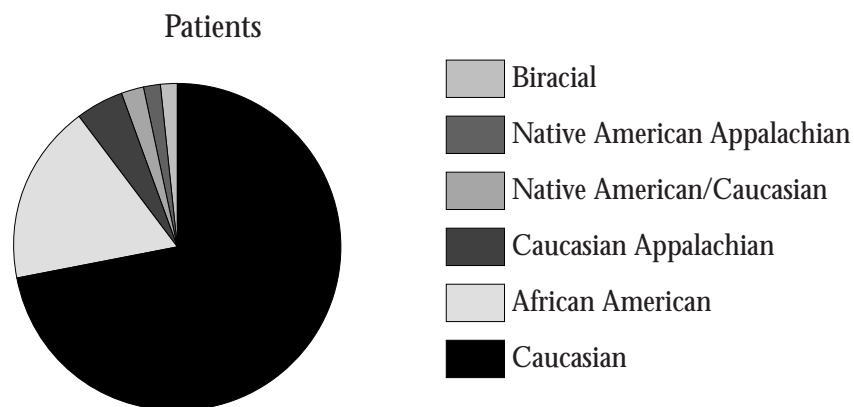
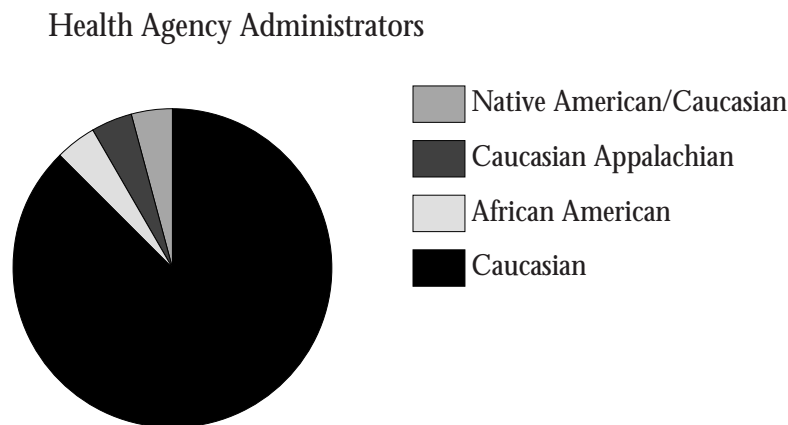
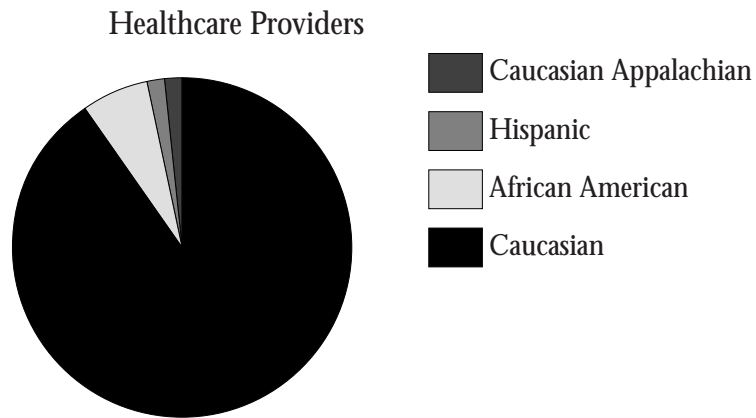
Eight counties were included in the survey: Adams, Brown, Butler, Hamilton, and Warren Counties in Ohio, and Boone, Campbell, and Kenton Counties in Kentucky. The researchers surveyed staff from 17 healthcare providers and patients at 15 health clinics.

Participants

A total of 218 participants were surveyed, and 203 were women. Most of the healthcare providers were nurses (70%), and most of the health agency administrators were either clinic directors (46%) or managers (25%). The total participants included:

- 64 healthcare providers;
- 24 health agency administrators; and
- 130 patients.

The figures below show the racial and ethnic backgrounds of the study participants.



Healthcare providers estimated that the largest single race or ethnic group served at their agency was Hispanic (32%), African American (31%), Caucasian (24%), Caucasian Appalachian (11%), Asian (1%), and East Indian (1%).

Health agency administrators also estimated the largest single racial or ethnic group served by their agency: Caucasian (54%), Hispanic (17%), African American (12.5%), Caucasian Appalachian (12.5%), and African American Appalachian (4%). A possible explanation for the disparity between the estimates is that administrators may have a different perception of the patients seen at their clinics than the healthcare providers have, or some respondents may have interpreted the questions differently than others.

Cultural Competency Policies and Services: Comparison of Administrator, Provider, and Patient Ratings

Health agency administrators indicated that their organizations encouraged its providers to attend training to improve their knowledge and skill in serving culturally diverse patients more than providers reported attending that type of training. Also, administrators indicated that their agencies encouraged providers to consider the patient's diverse backgrounds in diagnosing conditions more than providers indicated that they followed this practice.

There were also differences between the ratings of healthcare providers and patients. Providers rated themselves higher than patients rated them in:

- considering the patient's cultural beliefs in developing treatment plans,
- considering a patient's use of culturally specific remedies,
- referring patients to community resources, and
- using culturally-oriented assessment instruments.

Cultural Competency Policies and Services: Patients at Urban and Rural Clinics

For all questions assessing cultural competence, patients at rural clinics rated providers higher than patients at urban clinics. The results from three questions showed that rural patients:

- indicated that healthcare providers were more likely to make sure they understood directions by repeating them,
- believed that their providers were more likely to allow them to try home remedies when such treatments would not harm their health, and
- indicated that providers were more likely to refer them to community resources.

Findings

A majority of administrators in the health agencies surveyed (83%) identified cultural competency as an important organizational concern. In addition, a majority of the participating organizations (88%) collected racial and ethnic data on patient populations, which could help them take cultural issues into account when diagnosing patients. However, less than half of the organizations had adopted a mission statement that explicitly made a commitment to cultural competence. Very few agencies (16%) had adopted a role to address cultural diversity. There was little ethnic diversity among the healthcare providers and administrators surveyed. The low representation of Asian American and Hispanic health professionals may become more problematic as these two ethnic groups rapidly grow in the region. There were also differing perceptions of the level of culturally competent practices by patients, administrators, and providers.

The differences in perceptions across groups suggest that agencies might benefit from internal audits, standards for addressing health encounters with ethnically diverse patients, and training to improve the skills of cultural competence. However, since respondents from different sites were not matched or controlled, limited conclusions can be drawn from this study.

A notable finding was that providers are already feeling an increasing presence of Hispanic patients. Providers described difficulties in locating Spanish language translators or in using resources such as telephone translation services. These issues will continue to emerge as limited-English and non-English speaking populations grow.

Best Practices Literature Review

Another major activity of the project was a literature review of best practices in cultural competence in healthcare. The literature review involved a bibliographic search of major health databases and a review of Internet resources. Report authors selected 60 publications and resources most relevant to the topic for review.

Professional health literature on cultural competence is promising. While there are significant challenges to the delivery of effective and culturally relevant health services, the 60 publications reviewed deliver a compelling message that cultural competence in primary healthcare contributes to:

- more appropriate diagnoses and treatment plans,
- more accurate communication between patients and healthcare providers,
- lower treatment costs, and
- improved health outcomes.

Four themes emerged in the review:

- language barriers;
- quality of communication between patients and healthcare providers;
- cultural influence on health beliefs, practices, and behavior; and
- involvement of family and community in healthcare.

Language Barriers

Several studies have found that non-English speaking patients who visit a healthcare facility where translation is unavailable are:

- less likely to understand their medical condition,
- less likely to understand the recommended course of treatment,
- less likely to make follow-up visits,
- more likely to report being dissatisfied with the visit,
- more likely to require diagnostic tests, and
- more likely to require longer time with the healthcare provider.

Misunderstandings due to language differences can have serious consequences, particularly with medications. The use of a professional medical interpreter is the ideal practice to resolve language issues. However, there are practical considerations to this approach—including cost, the variety of

languages to be encountered, and the small number of ethnic patients in clinic settings—that make it hard to justify and find full-time interpreter employees. A possible strategy for healthcare providers is to explore ways to use telecommunications for translation services. The use of “community interpreter banks”—lists of trained interpreters in the area who work on an on-call basis—has also been successful in many regions.

Communication Between Patients and Healthcare Providers

In cross-cultural exchanges, the potential for miscommunication goes far beyond language differences to include nonverbal behavior, communication style, perceptions of being heard, and level of language used. Research on ethnic and cultural groups consistently identifies negative attitudes toward health providers as a major barrier to the use of services. To improve communication with ethnic patients, it is important for healthcare providers to examine their own belief systems to become aware of potential biases and stereotyping that may block positive communication.

Social conversation at the start of a medical encounter has significant positive impact on patient satisfaction. Attention to the physical environment also contributes to creating a positive atmosphere, communicating respect and sensitivity to patients’ ethnic backgrounds. Patients appreciate the display of pictures, posters, magazines, videos, brochures, and other materials that reflect their cultural and linguistic heritage.

Cultural Influence on Health Beliefs, Practices, and Behavior

An individual’s cultural background usually influences the way he or she views the causes of illnesses, seeks help for health concerns, and responds to medical procedures or treatment programs. Many cultural groups are unaccustomed to the concept of preventive healthcare as it is understood in the mainstream U.S. culture. Often, the first course of action in many cultures is to treat minor ailments within the family using folk remedies such as herbs, ointments, or special diets. Turning to the healthcare system may occur only when these approaches fail. Visiting healthcare facilities may traumatize patients who lack understanding of medical procedures, or whose traditional beliefs or distrust clashes with the treatment procedures.

Family and Community Support Systems

The family support system is important to good health and may be especially important for ethnic or cultural populations. An individual’s first understanding of health concepts, causes of illnesses, and healthcare is passed down from family members. A person may only consult a medical professional if the illness requires help beyond what is available through family and community resources. Possible strategies using family and community support systems include:

- allowing family members to participate in health decision-making,
- accommodating the need for extended family members to get information and provide support to the patient,
- assessing the family support system and how it might be used to achieve good health outcomes for the patient,
- developing community-wide support systems for ethnic health promotion projects, and

- making use of respected community leaders to serve as health educators or health promotion advocates.

Recommendations

Many recommendations require no financial support to implement. It does not take additional resources to involve families in the patients' dealings with the healthcare organization and to exercise extra care in communicating with a patient whose primary language is not English. Agencies need to encourage and reward culturally sensitive practice. Health providers should assess their beliefs, potential biases, communication style, and practices and make efforts to achieve cultural competence. The interest and cooperation of the agencies participating in this research clearly reflected the agencies' and providers' understandings of the need to provide more effective and culturally appropriate healthcare to patients of diverse backgrounds.

The following recommendations were proposed to improve the cultural competence of safety net providers:

- Improve language resources.
 - Explore the feasibility of establishing community interpreter services.
 - Sponsor educational conferences for health service providers within the region.
- Engage existing resources, such as quality improvement programs, to improve culturally sensitive clinical practices.
- Encourage agency planning to address emerging issues of cultural competence.
- Increase diversity in the healthcare workforce.
- Develop demonstration programs that can be implemented in the region.