Assessing Cultural Competence at a Local Hospital System in the United States

Georgia N.L.J. Polacek, PhD; Rubén Martinez, PhD

Cultural competence in health care has come to the forefront with the changing demographics in the United States. Standards have been created by the Office of Minority Health for culturally appropriate health care. This article presents the findings of one hospital system’s cultural competency assessment. Employee surveys and patient and physician focus groups were conducted to gain insight into cultural differences and challenges encountered in this system. Statistically significant effects of ethnicity and gender on language skills and awareness, as well as differences in awareness and knowledge by the respondent’s employment position, were found. Patient concerns included access to care and respect from staff. The need for cross-cultural education and training for all health care delivery personnel was reinforced. Cultural competency will not be achieved if education, attention to diversity, trained interpreters, and the understanding that social factors have a profound influence on health and health outcomes are not considered. Key words: cultural competency, diversity, hospital systems, multiculturalism

According to the US Census Bureau,1 nearly one-third (30%) of the nation’s population is composed of racial or ethnic minorities, with Hispanics making up the largest ethnic minority group at 15% of the population. This demographic shift has occurred over the past couple of decades and is due primarily to immigration, increased birth rates, and decreased death rates.2 Because of these changing demographic patterns, cultural competency in service delivery has gained renewed emphasis not only in health care but also across a broad range of sectors in society.3,4 Historically, racially segregated health care contributed to the disparities found across the major race/ethnic groups in the United States, including significant differences in access, utilization, and quality of services.5,6 Cultural competent health care seeks to remedy this situation.

Cultural competency is the collection of behaviors, attitudes, skills, and policies that facilitate the delivery of services to individuals in ethnically diverse situations.7,8 Recognizing the role of culture in health means an acknowledgment of the importance of shared values, perceptions, and beliefs related to health. Culture is directly related to health promotion, disease prevention, early detection, access to healthcare, trust and treatment compliance.9(p31) Reynolds,10 citing Brach and Fraser,11 stated that cultural competence makes good business sense and that a proactive approach to cultural competence in health care delivery will avoid economic repercussions from Medicare and Medicaid. “The goal of culturally competent healthcare is to assure the provision of appropriate services and reduce the incidence of medical errors resulting from misunderstandings caused by differences in language or culture.”12(p70)

This article provides findings from an assessment of cultural competency at a public hospital system in a large southwestern city. The findings are reported with respect to the
National Standards on Cultural and Linguisti-
cally Appropriate Services set by the Office
of Minority Health (OMH) and following
the scheme of Anderson et al and Sue
et al. In addition, we discuss the compo-
ponent of organizational behavior as described
in Drechslin et al in health disparities ini-
itiatives. The assessment of cultural compet-
tence was conducted at the request of the
hospital system as part of a comprehensive
planning process of its ambulatory care sys-
tem. A research team of faculty members and
research assistants from 2 research centers of
2 local institutions of higher education was
assembled to conduct the study. Although
the assessment also focused on policies, or-
ganizational documents, and other aspects of
the organization, this article focuses on the
perceptions of staff, patients, and physicians.
For more information on the overall assess-
ment, see Medrano et al.

**Culturally competent health
care settings**

The standards for cultural competence in
health care settings established by the OMH
are intended to be inclusive of all cultures and
not limited to any particular population group
or sets of groups; however, they are especially
designed to address the needs of racial, ethnic,
and linguistic population groups that experi-
ence unequal access to health services. Ulti-
mately, the aim of the standards is to contribute
to the elimination of racial and ethnic health
disparities and to improve the health of all
Americans.

The assessment and enhancement of cul-
tural competence among professionals in the
health care industry in the United States have
been gaining support over the past 2 decades.
Organizational policies are important features
of any assessment of capacity in organizations
for they not only set the tone for what is
considered important within the organization
but also impact the delivery of services.

Many of the problems of cultural compe-
tence in the delivery of medical services can
be traced to the training of medical physicians
and practitioners. The medical model used by
health care workers is usually framed in a
Eurocentric epistemology that has been de-
veloped through traditional education and prac-
tice and by the power hierarchy that circumscribes the “expert” in a credential
society. Anglo-American physicians may hold
negative stereotypes of race/ethnic minority
groups and their members and may not
be aware of the role that culture plays in
physician-patient interactions. Because cul-
tures are not homogenous, stereotypes can be
useful as mental shortcuts. However, because
these stereotypes are embedded in broader
intergroup relations of domination and sub-
ordination, they can, at the same time, be
damaging to medical relationships. Although
stereotypes may not be evident, providers’
perceptions about and attitudes toward race/
ethnic minorities may also influence treat-
ment decisions. In addition, the “expert
role” may blind medical practitioners on the
need to develop multicultural sensibilities. By
being culturally competent, “healthcare pro-
viders increase their ability to understand and
treat a culturally diverse clientele with varied
health beliefs and practices, thus improving
accuracy of diagnoses and selection of ap-
propriate treatments.”

One primary component of culture is lan-
guage. Language is a complex part of cul-
ture. Understanding and communication are
functions not only of the words spoken by
a person but also of intonation, pronuncia-
tion, volume, and word choice. Healthcare
settings may raise both linguistic and cul-
tural barriers for ethnic groups. Limited
English proficiency and lack of ethnic match
between staff members and clients may de-
crease or delay healthcare-seeking behav-
ior. The failure of people from other
cultures to grasp or follow treatments pre-
scribed by their physicians is normally
viewed as a failure on the patient’s part.
However, physicians use clusters of informa-
tion when making treatment decisions and
differences in language and culture may
impact how that information is revealed be-
tween patient and physician.

“Culture defines how health information
is received, understood, and acted upon;
language is a powerful transmitter of culture.\textsuperscript{1,12(p74)} Attributes such as age, gender, race, educational attainment, regional customs, social class, and socialization can also affect communication. The differences in communication may also be a mismatch of ethnicity of physician and ethnicity of patient\textsuperscript{3-5} or simply a lack of common language.

Non-English-speaking patients may not understand why they are taking a prescription or the diagnosis provided them. Thus, patients may take a physician's order literally because they will not question their physician to clarify meanings of words. Moreover, because many immigrants feel subordinate to the physician, they do not question what they are being told to do.\textsuperscript{5}

At times, health care professionals use interpreters either through the patient's family or through other hospital workers.\textsuperscript{3} This may cause potential problems because a younger relative or untrained hospital worker may not understand the terminology that the physician is using, thus leaving the physician with a false sense of security that the patient is getting the correct message. Indeed, there are many reasons why this model is inappropriate for effective communications in these settings. Translators trained in medical terminology are necessary to ensure accurate delivery of information.

Literacy levels play a compounding role in patient-provider interactions.\textsuperscript{3} There are instances where patients may not read in any language; therefore, providing printed materials in the patients' first language is not an optimum solution to the communication problem. In addition, many adults in the United States have “limited health literacy,” so even if patients speak English, they may not understand the physician's medical language.\textsuperscript{20} Low literacy is embarrassing to many adults. They may not admit that they cannot read the pamphlets that the physician has given to them. Problems also occur when patients do not follow medication instructions because they cannot read them.\textsuperscript{3} Thus, low literacy levels can lead to decreased patient health and increased medical costs.\textsuperscript{20}

Another component of cultural competency is that of diversity. Health care providers who differ ethnically or racially from their patients may increase patient mistrust and noncompliance. Many ethnic minority patients mistrust Anglo-American medical providers.\textsuperscript{3,4,18,21} In addition, life experiences of minorities outside the realm of health care are apt to influence their perceptions of and responses to health care professionals and settings.\textsuperscript{19} Trust is a valuable factor in health care. Lack of trust tends to result in lack of compliance with physician instructions and use of medications. This also leads to decreased patient health and increased health care costs.

Therefore, because of the foregoing issues, culturally competent health care has a culturally diverse staff that reflects the community served. For example, in Texas, Hispanics and African Americans make up 43% of the population but only 14% are physicians.\textsuperscript{21} Gray and Stoddard\textsuperscript{22} note that it is not clear whether minorities visit doctors of their same race/ethnicity because that is their preference or because that is who is located in their neighborhood. Research findings on this issue have been mixed. For example, Saha et al\textsuperscript{23} were able to show that it is preference and not access limitations that result in similarity between the race/ethnicity of physicians and patients. In earlier work, Bertakis found that “minorities do not express a preference for race of physician.”\textsuperscript{24(p297)} It is unclear as to whether race impacts physician-patient similarity and how it impacts patient satisfaction. However, a diverse health care workforce may aid in providing appropriate services and “achieving diversity at all levels of the organization can influence the way the organization serves the needs of clients of various cultural and linguistic backgrounds.”\textsuperscript{12(p73)} The diversity of health care providers may increase trust, patient satisfaction, and compliance, which then improves patient health.\textsuperscript{4}

Anderson et al\textsuperscript{12} conducted a systematic review of health care systems, looking for evidence of the components stated above. They found insufficient evidence to determine
any effectiveness of specific programs on improving cultural competency in health care settings. Their call for research is a primary purpose of this article.

Sue et al. stated that cultural competency can be measured through knowledge, beliefs and attitudes, and skills. Knowledge refers to acquired information about beliefs, respect, and stereotypes of other cultures. Beliefs and attitudes refer to the awareness of one's own culture and how this affects interactions with persons from other cultures. Skills refer to behaviors used when interacting with persons from other cultures, including language and communication.

This initial assessment was conducted to determine a cultural competency of a health care setting. Not only were knowledge, attitudes, beliefs and skills assessed, but also, evidence of culturally diverse staff, use of language and interpreters, and a general perception of cultural acceptability from patients' perspectives were explored. The purpose of this article was to describe the baseline assessment factor analysis findings and discuss how the findings can be used in program planning to ensure the hospital system meets the OMH standards.

METHODS

Population studied

The hospital system in this study is located in a metropolitan area of the southwestern region of the United States, with a combined local metropolitan and rural population of more than 2 million persons. This hospital system is a prestigious leader in patient care and research, providing a public hospital and a comprehensive range of health services and medical programs designed to meet the public's health care needs. It also provides a primary teaching hospital and employs more than 4,000 health care workers. The budget averages more than $615 million annually.

The population of the area served by the system is primarily Hispanic/Latino (58%), some of whom are newly arrived, some are undocumented, whereas most are long-time, intergenerational residents of the nearby communities. The average age of the local population is 26 years; fewer than 26% of adults hold college degrees. Chronic diseases, including heart disease, cancers, and diabetes, are the leading causes of death. Challenges encountered in delivering health care to this vast population include cultural competency, literacy issues, access to services, and poverty.

To gather information about cultural knowledge and perspectives of the hospital system, data were collected via surveys and focus groups. A random sample of employees was invited to complete the survey. Focus groups were conducted with patients and physicians. For more information on the overall assessment, see Medrano et al. The survey instrument was developed by one of the faculty members of the research team following discussions with the research team and on the basis of a detailed literature search of factors reflecting cultural awareness. The survey instrument consisted of 137 items in 3 areas of inquiry: cultural knowledge, perceptions and perspectives, and views of the cultural competence of the institution. Demographics consisting of age, gender, ethnicity, education, years employed, and position were included. Surveys were administered at work to a random sample of employees who were invited to participate. Data were entered and analyzed, as surveys were completed. Completed surveys were stored offsite at the research team office to maintain confidentiality and anonymity.

The focus groups included 5 patient groups and 1 physician group. The purpose of the focus groups was to describe their experiences in the health care system, their satisfaction with services, and to provide recommendations. A primary facet was to examine cultural competence as an issue for participants.

Sample

One hundred fifty-six employees of the hospital system completed the survey instrument, out of a population of 718, for a
response rate of 22%. The characteristics of the sample are as follows: women were 77.6% of the sample; 55.1% were Hispanic, nearly 13% were African American, and 14% were Euro-American; the modal age was between 31 and 45 years, and nearly 72% were between 31 and 65 years of age; 40% had some college, 23.7% had a bachelor’s degree, whereas approximately 12% had completed graduate school. As to their occupations, most of the respondents were in either clinical (29.2%) or clerical (25.3%) positions, followed by 16.9% in technical positions. Only 3.9% of respondents were physicians, and 11.7% were in management positions.

Focus groups were conducted with patients and physicians to ascertain their perspectives of their experiences and observations as participants in the hospital clinics and to provide recommendations to the hospital system specifically related to cultural competency. For complete information on the full assessment, see Medrano et al.16,17

According to Garson,26 focus groups should be led by trained facilitators, be between 5 and 10 participants, and use a flexible format of questions. Five focus groups were conducted with patients from the hospital’s various clinics. As is common, the focus groups were composed of a nonrepresentative, self-selected sample of patients who agreed to participate in the discussions. Most of the participants were women (76%) and Hispanic (82%). No other demographic data were collected from focus group participants. Group sizes ranged from 5 to 8 participants. One focus group was conducted with 5 physicians from one of the clinics. The physician focus group was composed of 3 males and 2 females; in terms of race/ethnicity, there were 2 Hispanics, 1 African American, 1 white, and 1 Asian American.16,17

All focus groups were conducted by a Chicano anthropologist with expertise in focus group facilitation. The focus groups were conducted between 6:00 and 8:00 PM. Food and beverages were provided to all participants. Focus group sessions were audi-taped, and notes were also taken. Anonymity and confidentiality were stressed repeatedly, and all participation was entirely voluntary.

RESULTS

Survey

The purpose of the survey was to gather information from employees regarding cultural knowledge, attitudes, beliefs, and skills of themselves and the hospital system. The 137 survey questions were grouped together to form composite index variables. By exploring the relationships between the instrument’s component factors, we wanted to determine how, in this testing set, they established a total score. The 4 composite index variables closely represented the central idea or statement of the group of questions. Seventeen index variables were formed (see Appendix). A reliability analysis was conducted to ensure that these index variables did indeed maintain the strongest reliability as measures of cultural competencies. Using these index variables, a factor analysis was conducted to determine which variables had the most influence on cultural competency.

Factor analysis is a technique used for the identification of factors by clustering variables into smaller homogenous sets and creating new variables.27 It was decided to set the cutoff point at 0.45 for inclusion or exclusion of a variable on a given factor because factor loadings are the basis for attributing interpretative labels to the different factors. The rule of thumb for factor loadings is that loadings less than 0.3 are not substantial.28,29 Garson states that “loadings above .6 are usually considered high and those below .4 are usually low.”26(p765)

Principal factors extraction with varimax rotation was performed on the 17 index variables. Cultural competency can be measured through knowledge, beliefs and attitudes, and skills.14 The expectation was that the 17 items would collapse into 5 factors, revealing the different dimensions of cultural competency that have been discovered in prior studies (ie, language, communications, awareness,
knowledge, and relationships). This expectation was verified in the factor analysis.

Five factors were extracted, with each of the 17 variables loading on only one factor as expected. Loadings of variables on factors, communalities, and percentages of variance are shown in Table 1. To facilitate interpretation, the variables were ordered and grouped by size of loading. Using the significant factor loadings, the 5 factors extracted were created into 5 separate indices demonstrating the different dimensions of cultural competency. These 5 indices were labeled language skills, communication skills, awareness, knowledge, and relationship.

Factor 1 was labeled language skills and was constructed into an index from the following 5 questions: (V18) I consider myself bilingual, (V19) I speak a language in addition to English at least somewhat, (V22) I speak a language other than English well, (V23) I read and write a language other than English, and (V24) I am comfortable with medical terms in a language other than English.

Factor 2 was labeled communication skills and was created into an index from the following 5 questions: (V9) I am good at talking to people from different cultural backgrounds, (V10) I have strategies to help people understand if they do not speak much English, (V11) I can tell how will people understand me if they do not speak much English, (V12) I know how to show courtesy to anyone, and (V13) I am able to help people resolve cross-cultural misunderstandings.

Factor 3 was labeled awareness and was created into an index from the following 2 questions: (V1) I know quite a bit about the history of Hispanics in the United States and (V2) I know quite a bit about the shared history of Texas/Mexico.

Factor 4 was labeled knowledge and was created into an index from the following 3 questions: (V4) family life and family values are similar in most cultures; (V5) beliefs about healing practices are similar in most cultures; and (V6) gestures, facial expressions, and other body language elements are similar in most cultures.

Finally, factor 5 was labeled relationship and was created into an index from the following 2 questions: (V14) I am sometimes confused by people’s accents and (V15) I am sometimes confused by the behavior of people from other cultural groups.

With the indices created from the factor analyses, 5 separate ordinary least squares regressions were run with the 5 measures of cultural competency (language skills, communication skills, awareness, knowledge, relationships) as the dependent variables with demographic, employee position, and cultural diversity indicators as predictor variables. Table 2 presents the descriptive findings of the 5 dimensions of cultural competency. Of the 156 employees in the dataset, nearly 45% reported high levels of awareness of other cultures, and over half (52.2%) reported high levels of communication skills with persons from a different culture. Just over a third (38.5%) reported they had high levels of skills in a language other than English, but just as many (35%) reported they had low levels of language.

Table 1. Factor loadings, communalities (h²) and percentages of variance for principal factors extraction and varimax rotation

<table>
<thead>
<tr>
<th>Item</th>
<th>f1</th>
<th>f2</th>
<th>f3</th>
<th>f4</th>
<th>f5</th>
<th>h²</th>
<th>Percent of Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>v22</td>
<td>0.92</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>v23</td>
<td>0.88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>v18</td>
<td>0.88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.79</td>
<td></td>
</tr>
<tr>
<td>v19</td>
<td>0.76</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>v24</td>
<td>0.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.47</td>
<td></td>
</tr>
<tr>
<td>v10</td>
<td>0.70</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.56</td>
<td></td>
</tr>
<tr>
<td>v11</td>
<td>0.66</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.48</td>
<td></td>
</tr>
<tr>
<td>v13</td>
<td>0.56</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.36</td>
<td></td>
</tr>
<tr>
<td>v9</td>
<td>0.54</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.39</td>
<td></td>
</tr>
<tr>
<td>v12</td>
<td>0.49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.29</td>
<td></td>
</tr>
<tr>
<td>v2</td>
<td>0.84</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>v1</td>
<td>0.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.74</td>
<td></td>
</tr>
<tr>
<td>v5</td>
<td>0.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.65</td>
<td></td>
</tr>
<tr>
<td>v6</td>
<td>0.67</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.49</td>
<td></td>
</tr>
<tr>
<td>v4</td>
<td>0.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.41</td>
<td></td>
</tr>
<tr>
<td>v14</td>
<td>0.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>v15</td>
<td>0.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.56</td>
<td></td>
</tr>
</tbody>
</table>

Percent of Variance: 20.77 11.39 9.63 9.06 5.46
skills. Only 14.7% of employees reported having high levels of knowledge of other cultures, whereas 43.6% reported low levels of knowledge.

The factor analysis showed statistically significant effects of ethnicity and gender on language skills ($F = 8.82$, $P < .01$) and awareness ($F = 2.47$, $P < .05$). No statistically significant effects emerged for the other 3 dimensions of cultural competency by ethnicity and gender.

To determine if ethnicity or gender had a significant influence on cultural competency, mean cultural competencies were analyzed by combining ethnicity and gender (ethgender). Table 3 presents the means for the 5 dimensions of cultural competency by the ethgender variables. The difference in language skill between the various ethgenders was quite substantial. Hispanic males and females reported highest on the language skills scale, whereas white males and females were the lowest. There were also significant differences between ethgender and awareness. Each of the male groups reported higher awareness than the females of the same race or ethnicity, with Hispanic males reporting the highest level of awareness. There were no significant differences in knowledge of other cultures between ethgender; however, black males and females reported the highest knowledge, whereas white females reported the lowest knowledge. Each of the ethgenders reported above average communication skills.

Table 2. Univariate distributions of cultural competency variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Valid Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>24</td>
<td>15.4</td>
</tr>
<tr>
<td>Medium</td>
<td>89</td>
<td>57.0</td>
</tr>
<tr>
<td>High</td>
<td>156</td>
<td>100</td>
</tr>
<tr>
<td>Mode = medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>33</td>
<td>21.2</td>
</tr>
<tr>
<td>Medium</td>
<td>53</td>
<td>34.0</td>
</tr>
<tr>
<td>High</td>
<td>70</td>
<td>44.8</td>
</tr>
<tr>
<td>156</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mode = high</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>16</td>
<td>10.3</td>
</tr>
<tr>
<td>Medium</td>
<td>58</td>
<td>37.2</td>
</tr>
<tr>
<td>High</td>
<td>82</td>
<td>52.5</td>
</tr>
<tr>
<td>156</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mode = high</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>57</td>
<td>36.5</td>
</tr>
<tr>
<td>Medium</td>
<td>59</td>
<td>35.0</td>
</tr>
<tr>
<td>High</td>
<td>60</td>
<td>38.5</td>
</tr>
<tr>
<td>156</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mode = high</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>68</td>
<td>43.6</td>
</tr>
<tr>
<td>Medium</td>
<td>65</td>
<td>41.7</td>
</tr>
<tr>
<td>High</td>
<td>23</td>
<td>14.7</td>
</tr>
<tr>
<td>156</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mode = low</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Mean cultural competency by ethgender

<table>
<thead>
<tr>
<th>Ethgender</th>
<th>Language skills</th>
<th>Awareness</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Hispanic male</td>
<td>3.97</td>
<td>0.94</td>
<td>3.96</td>
<td>0.89</td>
<td>2.52</td>
</tr>
<tr>
<td>Hispanic female</td>
<td>3.69</td>
<td>1.01</td>
<td>3.31</td>
<td>0.97</td>
<td>2.89</td>
</tr>
<tr>
<td>White male</td>
<td>2.17</td>
<td>0.89</td>
<td>4.00</td>
<td>0.95</td>
<td>2.61</td>
</tr>
<tr>
<td>White female</td>
<td>2.38</td>
<td>0.86</td>
<td>3.30</td>
<td>0.54</td>
<td>2.00</td>
</tr>
<tr>
<td>Black male</td>
<td>2.47</td>
<td>1.51</td>
<td>3.83</td>
<td>0.29</td>
<td>3.22</td>
</tr>
<tr>
<td>Black female</td>
<td>2.44</td>
<td>1.35</td>
<td>2.88</td>
<td>0.94</td>
<td>2.88</td>
</tr>
<tr>
<td>Other male</td>
<td>2.61</td>
<td>1.54</td>
<td>3.50</td>
<td>1.64</td>
<td>2.33</td>
</tr>
<tr>
<td>Other female</td>
<td>2.42</td>
<td>1.14</td>
<td>3.45</td>
<td>0.67</td>
<td>2.48</td>
</tr>
<tr>
<td>Total</td>
<td>3.13</td>
<td>1.25</td>
<td>3.41</td>
<td>0.95</td>
<td>2.71</td>
</tr>
</tbody>
</table>

Abbreviations: ethnicity and gender, ethgender; ns, not significant.
with other cultures, with black and Hispanic males reporting the highest skills. Finally, there is very little variation in between the ethgenders in the relationship scale. Black males scored slightly higher, whereas white males scored the lowest.

Finally, to determine if employee position (management, clinical, technical support, other professional, clerical, physician) influenced cultural competency, mean cultural competencies were analyzed by employee position. Table 4 presents the means for the 5 dimensions of cultural competency by the employee position of the respondent. The analysis showed statistically significant differences in awareness ($F = 3.99, P < .01$) and knowledge ($F = 4.42, P < .01$) by the position of the respondent. Few significant effects emerged for the other 3 dimensions of cultural competency. Examining the different positions held by respondents, we observed that physicians had greater language skills, whereas management scored the lowest on the language skills scale. Physicians also reported having the highest level of awareness, whereas those respondents working in clinical positions reported the lowest levels of awareness. There was very little variation between the other professions. When it came to knowledge, other professionals had the highest means on the knowledge of other cultures, whereas physicians had the lowest means on knowledge of other cultures. Physicians, however, had the highest mean with regard to communication skills; there was very little variation in communication skill between the other professions. Finally, those in clerical positions reported the highest mean with regard to the relationship scale, whereas management and physicians had very low means.

**Focus groups**

As stated previously, the focus groups were conducted with patients and physicians to gather information about their experiences and observations as participants in the hospital clinics and to provide recommendations to the hospital system specifically related to cultural competency. The findings from the patient focus groups are presented first, followed by those from the physicians. For patients, access, outcomes, and satisfaction were the 3 primary themes regarding health care. Access included contact with the hospital system, specifically making appointments, reception, and registration. Access was perceived as positive and negative, that is, some reported positive experiences and others reported negative ones. The negative experiences with access included different telephone numbers for making appointments, contacting physicians, or doing other services, which led to confusion and frustration and was a time-consuming

Table 4. Mean cultural competency by position

<table>
<thead>
<tr>
<th>Position</th>
<th>Language Skills</th>
<th>Awareness</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Management</td>
<td>2.89</td>
<td>1.22</td>
<td>3.50</td>
<td>0.84</td>
<td>2.17</td>
</tr>
<tr>
<td>Clinical</td>
<td>3.10</td>
<td>1.22</td>
<td>3.10</td>
<td>1.02</td>
<td>2.64</td>
</tr>
<tr>
<td>Technical support</td>
<td>3.08</td>
<td>1.07</td>
<td>3.46</td>
<td>1.00</td>
<td>2.97</td>
</tr>
<tr>
<td>Other professional</td>
<td>2.99</td>
<td>1.46</td>
<td>3.45</td>
<td>0.69</td>
<td>3.21</td>
</tr>
<tr>
<td>Clerical</td>
<td>3.31</td>
<td>1.31</td>
<td>3.44</td>
<td>0.91</td>
<td>2.78</td>
</tr>
<tr>
<td>Physician</td>
<td>3.51</td>
<td>1.63</td>
<td>4.83</td>
<td>0.41</td>
<td>1.56</td>
</tr>
<tr>
<td>Total</td>
<td>3.12</td>
<td>1.26</td>
<td>3.41</td>
<td>0.96</td>
<td>2.71</td>
</tr>
</tbody>
</table>

$F = .45 \quad F = 3.99 \quad F = 4.42 \quad F = .93 \quad F = 1.06$

$P = ns \quad P = .00 \quad P = .00 \quad P = ns \quad P = ns$

$\eta^2 = 0.02 \quad \eta^2 = 0.12 \quad \eta^2 = 0.13 \quad \eta^2 = 0.03 \quad \eta^2 = 0.04$

Abbreviation: ns, not significant.
problem. Negative attitudes and lack of respect from reception staff were also a major concern in access. Outcomes were classified as patients’ experiences with clinical providers. Outcomes were generally positive, and most patients had a high level of satisfaction with treatments and clinic providers. Satisfaction was also a component of outcomes. Satisfaction was defined as patients’ evaluation with clinic services and any follow-up contact with the hospital system. Specific examples of dissatisfaction were given by most patient respondents. These included disrespect, miscommunication, and difficulty working with the hospital pharmacies. Other problems cited were the length of time between appointments, inconsistencies among the pharmacies in the system, length of time to get prescriptions filled, and the often lengthy time involved in nurse callbacks. Continuity of care was also a concern for all patients.

Legislative cutbacks in the area of health care have occurred, and patients reported that these had an impact on access to and satisfaction with health care. Many patients feared that more cutbacks would have serious negative health effects. In general, they stated that the cutbacks would increase the number of uninsured persons or families. Many patients identified themselves as working poor and had limited health care access. Either their employers did not offer insurance or employees did not choose the insurance because the employee’s portion was too expensive and they were ineligible for the hospital programs because those were too expensive as well. As stated previously, access to health care, including affordability, has an impact on health.

With respect to cultural competency, most patients stated that most of the staff at the clinics knew Spanish. However, the lack of interpreters and interpreter training was cited as a problem. Most participants also stated that physicians were knowledgeable and respectful of the Hispanic culture.

The physicians’ focus group noted many administrative problems along with the positive aspects of the hospital programs. In addition, continuing education for clinical staff members was needed, yet the staff members were unable to attend because of costs. Preventive care was also noted as a necessity, with public health education a priority. Issues of access were also acknowledged, including patients’ lack of transportation, the difficulties encountered in making appointments, and the need for more communication between clinics and with patients. As stated earlier, access to health care, including availability of both clinics and transportation, can affect both patient satisfaction and compliance with treatment.

**DISCUSSION**

According to Sue et al, knowledge, attitudes and beliefs, and skills are the 3 measurable areas of cultural competency. These components are reflected in the 5 factors found in the analyses: language skills, communication skills, awareness, knowledge, and relationships. Attitudes and beliefs are found in awareness and relationships. Knowledge and skills are intrinsic in those respective areas. Skills, awareness, and knowledge are reflected in relationships. Knowledge, attitudes and beliefs, and skills are needed to ensure that patients receive care that is effective, respectful, and understandable within the context of their cultural beliefs. The results reported 5 dimensions of cultural competency. Almost half of participants reported awareness of other cultures, and over half reported high levels of communication skills with other cultures. Language skills were evenly distributed, with a third reporting high levels and a third reporting low levels. Knowledge of other cultures was markedly low for almost half of the respondents.

Culturally competent health care should have a culturally diverse staff that reflects the community served. It seems that the hospital system employees are culturally diverse and reflect the community served. Discrimination and stereotyping were not evident from the survey data or the focus groups. The factor analyses indicated that Hispanic respondents had greater levels of awareness.
of ethnic differences and scored higher on language skills and whites tended to score lower on these factors. As found by others,\textsuperscript{31,32} respondents from ethnic minority groups had greater levels of awareness about ethnic differences. This result is suggestive of the inherent ethnocentrism that tends to exist in the white US population today, as second languages are not required in schooling and cultural identity is not as important in the white population.\textsuperscript{3,5} The results indicate that the hospital employees were varied in their cultural competencies and that there was room for improvement. Training and increasing the diversity of the workforce can increase the cultural competency of the hospital system.

Improving cultural competency among those employed in the health care system is necessary to ensure that bias and discrimination are not part of the problem of health disparities.\textsuperscript{4,15} Cross-cultural education is necessary for all health care workers, not only for direct care providers.\textsuperscript{12} The hospital system should progress with cultural education activities to ensure that they are adequately meeting the needs of their patients and consumers. This education can improve cultural competency and may also reduce health disparities by addressing the diversities inherent in working with minority populations.\textsuperscript{10,11,15,33}

Communication and language skills are critical in cultural competency.\textsuperscript{3,5} Focus group patient participants reported instances of disrespect and negative attitudes of clinic staff. Ensuring that communication is optimal by all parties is necessary for optimum outcomes. Training in customer service (skills) for all hospital personnel may improve cultural competency simply because the training serves as a mechanism for improving communication skills.

Lack of adequate interpreters was cited as a concern in the focus groups. This is one of the primary standards from OMH\textsuperscript{13} and needs to be considered throughout the health care arena. One approach for improving patient education and interpretation services is the utilization of lay health workers. Lay health workers (also known as community health workers and promotoras/promotores) are those individuals who have some professional education and training in the medical setting. Lay health workers can function as interpreters, provide some basic education regarding diagnoses and treatment, clarify medication instructions, and act as advocates for patients.\textsuperscript{34} Through improvement of the patient’s level of understanding about their health, patients become empowered and are able to be more fully involved within the health care arena and potentially in treatment decisions. Increased understanding among patients might also improve prevention, a concern cited by the physicians in the focus group. Use of lay health workers can be a strong component of culturally competent health care.

Some of the clinics are local (located in neighborhoods), which addresses the culturally specific settings component.\textsuperscript{13} However, other challenges were found. Continuity of care was a theme in the focus groups and was cited by Howard et al\textsuperscript{3} as a primary challenge to culturally competent care. Simply having clinics in neighborhoods does not ensure continuity of care. Other issues relating to funding and hospital policies instead were causes for concern. Although not inherent in the standards, these issues need to be remedied to improve health outcomes for the patients and consumers of the hospital system.

**Limitations**

Some limitations exist in the study. These include voluntary participation, response rates, and self-report. As participation in the survey and focus groups was voluntary, results must be viewed with caution. The response rate of the survey was 22%. This is lower than what is considered ideal. As a voluntary mechanism, the survey was limited. A bias in self-report data has been noted by others,\textsuperscript{26,35} with respect to social desirability. Some of the association between higher education and higher cultural competence in the survey may actually be due to the social desirability bias. Physicians, for example, may not be as culturally competent as they
perceive themselves to be. Finally, the generalizability of the findings is limited to this hospital system.

CONCLUSION

This hospital system examined, among other things, perceptions of patients, staff, and employees relative to its policies and practices. Next steps were then determined to ensure and maintain a culturally competent system. The system has several strengths (diversity and clinic location) and some areas for improvement (increasing cultural awareness and appropriate translators). The article presents the findings from a factor analysis and focus groups with respect to the knowledge, attitudes and beliefs, and skills of cultural competency. The descriptive data reported here provide an avenue for further study.

More importantly, the findings here serve to support the need for cross-cultural education in health care delivery, the appropriate use of trained interpreters, and the understanding that socioeconomic and cultural factors have a profound influence on health and health outcomes. Addressing these issues is a primary step in eliminating health disparities.

ACKNOWLEDGMENTS

The authors thank Darla R. Norton and Leslie Davila, Culture and Policy Institute, University of Texas, San Antonio, for their assistance with this article.

REFERENCES

Culture and Policy Institute, Hispanic Medical Center of Excellence, and University Health Science System; 2003.


APPENDIX
QUESTIONS THAT COMPRIZE EACH FACTOR

AWARENESS

(V1) I know quite a bit about the history of Hispanics in the United States.
(V2) I know quite a bit about the shared history of Texas/Mexico.

KNOWLEDGE

(V4) Family life and family values are similar in most cultures.
(V5) Beliefs about healing practices are similar in most cultures.
(V6) Gestures, facial expressions, and other body language elements are similar in most cultures.

SKILLS

(V9) I am good at talking to people from different cultural backgrounds.
(V10) I have strategies to help people understand if they do not speak much English.
(V11) I can tell how will people understand me if they do not speak much English.
(V12) I know how to show courtesy to anyone.
(V13) I am able to help people resolve cross-cultural misunderstandings.

LANGUAGE

(V18) I consider myself bilingual
(V19) I speak a language in addition to English at least somewhat.
(V22) I speak a language other than English well.
(V23) I read and write a language other than English.
(V24) I am comfortable with medical terms in a language other than English.

RELATIONSHIP

(V14) I am sometimes confused by people’s accents.
(V15) I am sometimes confused by the behavior of people from other cultural groups.