Overview of Cultural Competence and the Occupational Health Care Workforce

By

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ABSTRACT

A wealth of literature has been published to assist and direct health care providers to deliver culturally competent services. This paper contains an extensive literature review on cultural competence for health care professionals, specifically occupational health professionals. Cultural competence is defined and ways to integrate cultural competence into occupational health care practices are explored. Approaches to increasing cultural competence in the workforce, implications for occupational health professionals, and recommendations to support cultural competence for occupational health professionals are also provided.
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CHAPTER 1

INTRODUCTION

Communication is the process by which one person's thoughts are formed into words that are received by another individual and translated into meaning for that individual. Miscommunication occurs with the development of errors in the reception or translation of the words into incorrect meanings. Cultural, socioeconomic, and political differences may create barriers and divergent meanings to the context of the words or phrases.

Since the creation of humanity, communication barriers existed between people of different races, genders, and nationalities. However, in the United States (US) health care setting, it takes on special meaning because of the growing diversity of cultures. As the non-English speaking population of the US continues to increase, the language barriers between the health care delivery system and minorities are also increasing. Health care providers must care for clients from many different cultural and linguistic backgrounds. Therefore, health care organizations and health care professionals must recognize and accommodate the needs of culturally and linguistically diverse clients (Office of Minority Health [OMH], 2001).

Racial and ethnic minorities account for a large percentage of the US workforce, mostly employed in construction, farming, and manufacturing (Amurao, 2004). "Disparities have been attributed to a
disproportionate representation of immigrants in occupations and industries that carry higher risks of injury and fatality, coupled with the workers’ lower levels of education and lack of English proficiency” (Amurao, 2004, p. 9). Occupational and environmental health nurses are critical to the identification of hazards and generation of solutions at the workplace.

This paper focuses on cultural competence in the workforce population. It presents definitions necessary to understand cultural competence and explores ways to integrate cultural competence into occupational health care practices. The role of occupational and environmental health nurses is critical in providing health care services to the racial and ethnic minority workforce. Occupational and environmental health nurses who are culturally competent provide better care for their clients which results in healthier outcomes. Recommendations to promote cultural competence in occupational health are discussed.
CHAPTER 2
LITERATURE REVIEW

Definitions

Health care professionals use many different approaches to eliminate communication barriers that stem from racial, ethnic, cultural, and linguistic differences. In recent years, the notion of "cultural competence" has come to encompass both interpersonal and organizational interventions and strategies that seek to facilitate achievement of clinical and public health goals when those differences come into play. Cultural competence has been variably defined by health care organizations and academic institutions. "Because health care is a cultural construct arising from beliefs about the nature of disease and the human body, cultural issues are central in the delivery of health services treatment and preventive interventions" (OMH, 2001, p. 4). By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, providers, and others can provide a health care system that responds suitably to, and serves the unique needs of populations whose cultures may be different from the American culture (OMH, 2001).

Culture

Culture is the combination of various models of human behavior that include the language, thoughts, communications, actions, customs,
beliefs, values, and institutions of racial, ethnic, religious, or social groups (Cross, Bazron, Dennis, & Isaacs, 1989).

Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given (OMH, 2001, p. 4).

Culture does not determine behavior, but gives people ideas on how to behave with themselves, with others, and with their environments. Culture is a complex collection of relationships, reactions, and interpretations that must be understood as a combination of backgrounds and traditions coming from a specific socioeconomic framework. Culture is ever changing and always being modified (Hunt, 2001).

**Cultural Competence**

The US Department of Health and Human Services (DHHS) adapted the definition of cultural competence from Cross et al. (1989) and defines cultural competence as a collection of similar behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Competence involves having the aptitude to perform effectively as an individual and an organization within the framework of the cultural beliefs, behaviors, and needs presented by clients and their communities (Anderson, Scrimshaw, Fullilove, Fielding, Normand, & the Task Force on
Cultural competence is also developmental, community focused, and family oriented. In particular, it is the promotion of quality health care services to underserved, racial/ethnic groups by valuing differences and integrating cultural attitudes and beliefs. It is also the continual advancement of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to guarantee that health care services are delivered in a culturally competent way (CEO Services, 2001). Cultural competence is a way to change the health outcomes of minority Americans as they generally receive less health care services due to racial and ethnic disparities and suffer worse health (Brach & Fraserirector, 2000).

With the nation’s increasing diversity, there is a growing need for the health care services that are culturally sensitive and appropriate. This necessity is present in all aspects of health and social services, including occupational health. To address this need, cultural competence allows health care providers to increase their understanding of cultural differences and to act sensitively, appropriately, and respectfully towards different cultures (Center on an Aging Society, n.d.).

Cultural competence involves the use of services and information in the language of the individual, family, or community. More often cultural competence is seen as a necessary attribute for health care professionals and health care programs to have in order to deliver quality health care to their communities. The Department of Health and Human Services has
promoted the development of cultural competence through initiatives, such as the 1998 Presidential Initiative to End Racial and Ethnic Disparities in Health, which aimed to train more racial and ethnic minorities in the health care field to reduce health disparities in these populations (McDonald, 2001).

Formal training of racial and minority health care workers is encouraged. Cultural competence has come to include both interpersonal and organizational involvement and approaches to obtain the success of clinical and public health goals (Fortier & Bishop, 2003). The goal of culturally competent health care services is to provide the highest quality of care to every client, regardless of race, ethnicity, cultural background, English proficiency or literacy (Center on an Aging Society, n.d.).

**Cultural Awareness**

According to Campinha-Bacote (1994), cultural awareness helps an individual to understand how and why people think, act, and do business in the way they do and also how they view the individual. “Such cultural awareness includes abstaining from forming biases and opinions based on one’s own cultural background” (Institute of Medicine [IOM], 2002, p. 241). The development of one’s sensitivity and understanding of another racial/ethnic group involves changes in one’s attitudes and values and the need to be honest and adaptable with others. Cultural awareness goes hand in hand with cultural knowledge.
Cultural Sensitivity

Cultural sensitivity is “the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic, or cultural heritage” (The Henry J. Kaiser Family Foundation, 2003, p. 6). Cultural differences as well as similarities exist and all people must not assign value -- for example, better or worse, right or wrong -- to those cultural differences. While ethics and attitudes refer to the principles held by health care professionals, cultural sensitivity presents itself in a health care provider’s ability to accurately understand and reply to non-verbal or other cultural cues. This sensitivity can show the way to the changes needed for cultural competence (Health Resources and Services Administration [HRSA] Care Action, 2002). In other words, cultural sensitivity is one’s awareness of the degree of one’s own culture and other cultures (Gilbert, 2003). Culturally competent health care providers are able to use their knowledge of the health-related beliefs and practices of clients to improve the quality of care they provide. Cultural competence is more than cultural sensitivity or awareness. Health care providers must have the knowledge and respect for different cultural perspectives as well as the skills that are needed to be effective in cross-cultural situations (HRSA Care Action, 2002).
Health Disparity

The National Institutes of Health (NIH) characterizes health disparities as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the US (National Institutes of Health, n.d.).

A health disparity should be viewed as a chain of events signified by a difference in: (1) environment, (2) access to, utilization of, and quality of care, (3) health status, or (4) a particular health outcome that deserves scrutiny. Such a difference should be evaluated in terms of both inequality and inequity, since what is unequal is not necessarily inequitable (Carter-Pokras & Baquet, 2002, ¶ 6).

Cultural Competence

Culture is a leading force in shaping actions, principles, and organizations. Not only do cultural differences exist, but they also affect health care delivery. Culturally competent providers recognize the value of family ties and understand that they are defined differently for each culture. Before being offended by another culture's point of view, culturally competent providers value and promote collaboration and cooperation with their clients (American Medical Student Association [AMSA], 2004). Besides health care providers being responsible for being culturally competent, minority groups have the responsibility to learn English as their second language. However, learning a new language and adapting to a culture vastly different from one's own takes time (Healthcare Task Force
of the Mayor's International Cabinet, 1999). Minority groups should also be aware of the importance of taking responsibility for their own health outcomes. As new immigrants continue to arrive, the US will be confronted with even greater challenges in helping immigrants bridge the gaps of language and culture in order to provide cost-effective and safe, quality healthcare (Healthcare Task Force of the Mayor's International Cabinet, 1999). Healthcare providers and clients share in the responsibility of cultural competence.

National Center for Cultural Competence

The National Center for Cultural Competence (NCCC) has identified several reasons why cultural competence should be incorporated into organizational policy. These reasons include the need to:

- respond to demographic changes in the United States,
- eliminate disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds,
- improve the quality of services and health outcomes,
- gain a competitive edge in the healthcare industry,
- meet legislative, regulatory and accreditation mandates, and
- decrease the likelihood of liability/malpractice claims (Cohen & Goode, 1999).

Each one will be discussed further in detail.
Demographics

In 2000, the foreign-born population accounted for 28.4 million, or 10.4% of the total US population which is a dramatic increase from previous years as illustrated in Figure 2.1 (Schmidley, 2001). In 2003, more than 33 million people in the United States were foreign-born and comprised approximately 11.7% of the total population and the trend is expected to continue (Larsen, 2004). Among the foreign born, 53.3% were born in Latin America, 25.0% in Asia, 13.7% in Europe, and the remaining 8.0% in other regions of the world as shown in Figure 2.2, demonstrating that the US workforce has become more diverse.

The composition of the American population is changing due to immigration patterns and considerable increases among racially, ethnically, culturally, and linguistically diverse populations, especially from Latin America. Health care organizations and programs, and federal, state, and local governments must employ changes in order to meet the health needs of this diverse population (Cohen & Goode, 1999). The demographic changes that are anticipated over the next decade amplify the importance of addressing disparities in health status. Groups currently experiencing poorer health status are expected to grow as a proportion of the total US population; therefore, the outlook on health of the United States as a whole will be shaped considerably by the success in improving the health of these minority groups.
FIGURE 2.1
FOREIGN BORN POPULATION AND PERCENT OF TOTAL POPULATION FOR THE UNITED STATES, 1850-2000

Source: Schmidley, 2001
FIGURE 2.2
FOREIGN BORN BY WORLD REGION OF BIRTH: 2003

(In Percent)

LATIN AMERICA 53.3
  Caribbean 10.1
  Central America 36.9
  South America 6.3

ASIA 25.0
OTHER REGIONS 8.0
EUROPE 13.7

Source: United States Census Bureau, 2003
Disparities in Health Status

Nowhere are the division of race, ethnicity, and culture more sharply drawn than in the health of the people in the US. Even with recent progress in overall national health from an increased focus on preventive medicine and new advances in medical technology, there are continuing disparities in the occurrence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaskan Natives, and Pacific Islanders as compared with the US population as a whole (Cohen & Goode, 1999). Figure 2.3 shows the disparity in health status of various racial and ethnic groups in the US (National Center for Health Statistics, 2004). A nationwide focus on health disparities is important as major changes develop in the way in which health care is delivered and funded.

Health care professionals must be aware of the importance of healthcare as a resource that is tied to opportunity and the quality of life for individuals and groups. The productivity of the workforce is closely linked with its health status, yet if some segment of the population, such as racial and ethnic minorities, receive a lower quality and intensity of healthcare then these groups are further hindered in their efforts to advance economically and professionally. It is therefore important from an egalitarian perspective to expect equal performance in healthcare, especially
FIGURE 2.3
RESPONDENT-ASSESSED HEALTH STATUS ACCORDING TO RACE
IN THE UNITED STATES, SELECTED YEARS 1991-2002

Source: National Center for Health Statistics, 2004 (Adapted from Table 57)
for those disproportionately burdened with poor health (IOM, 2003, p. 36).

**Quality of Services and Health Outcomes**

People differ based on nationality, ethnicity, and culture, as well as family background and individual experiences which affect their health beliefs and behaviors. Cultural knowledge and understanding are important to personnel who are responsible for quality assurance programs. Cultural competence is unavoidably linked to particular health outcomes and to constant accountability that is committed to reducing the current health disparities among racial, ethnic and cultural groups (Cohen & Goode, 1999). Cultural competence provides improved quality of health care services leading to healthier outcomes for clients.

**Competitive Edge in Healthcare Industry**

In the current social and political environment, soaring health care costs and quality and effectiveness of service delivery continue to be of greatest concern. Health care organizations must encourage their providers to obtain cultural knowledge and to acquire skill sets that will enable them to work efficiently with diverse client populations. “Implementing culturally competent service delivery systems can definitely impact provider recruitment and retention, patient access to and satisfaction with care, and maintain or increase market share” (Cohen & Goode, 1999, p. 5).
Legislative/Regulatory/Accreditation Mandates

Cultural competence must meet legislative, regulatory, and accreditation mandates. The federal government ensures culturally competent health care services to all people. Title VI of the Civil Rights Act (1964) mandates that no person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. Organizations and programs have the responsibility to comply with federal, state, and local regulations for the delivery of health services. The Bureau of Primary Health Care, in its Policy Information Notice 98-23, recognizes that:

Health centers serve culturally and linguistically diverse communities and serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socioeconomic status, housing status and regional differences. Organizational behavior, practices, attitudes and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-
speaking ability, in programs offered by the health center (Cohen & Goode, 1999, p. 4).

**Liability/Malpractice Claims**

A lack of awareness about cultural differences can result in legal liability. For example, health care providers may find out that they are legally responsible for damages as a result of treatment without informed consent. Health care organizations and programs also face potential claims that their failure to understand an individual’s health beliefs, practices, and behavior violates professional standards of care. In some states, failure to follow instructions because they conflict with values and beliefs may cause a presumption of negligence on the part of the health care provider (Cohen & Goode, 1999).

Cultural competence decreases the likelihood of potential lawsuits. The Michigan Physicians Mutual Liability Company provides malpractice policies so that physicians receive a 2-5% premium reduction if they take a seminar on cultural diversity (American Medical Student Association, 2004). The ability to converse clearly with patients has been shown to be effective in reducing the likelihood of malpractice claims (Cohen & Goode, 1999).

A 1994 study indicated that patients of physicians, who were frequently sued, had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible, and willing to communicate (Levinson, Roter,
Mullooly, Dull, & Frankel, 1997). When health care providers treat clients with respect, listen to them, give them information, and keep communication lines open, relationships are improved and health care personnel reduce their risk of being sued for medical mismanagement (Levinson et al., 1997).

**Barriers to Cultural Competence**

There are barriers to cultural competency. “Effective communication between providers and clients is even more challenging when there are cultural and linguistic barriers” (Cohen & Goode, 1999, p. 5). The inability to communicate with a healthcare provider not only creates a barrier to accessing health care but also undermines trust in the quality of medical care received and decreases the likelihood of appropriate follow-up (Anderson et al., 2003). These barriers need to be addressed to insure accurate communication of information.

Another barrier is the lack of diversity in health care’s leadership and health professional workforce. “Minorities make up 28 percent of the US population but only 3 percent of medical school faculty, 16 percent of public health school faculty, and 17 percent of all city and county health officers” (Betancourt, Green, & Carillo, 2002, p. 3). This is a major concern because minority health care professionals in general may be more likely to take into account socio-cultural factors when organizing health care delivery systems to meet the needs of minority populations (Betancourt et al., 2002).
The current health care system is also poorly designed to meet the requirements of diverse patient populations. Workforce diversity in the healthcare setting is seen as a means of providing appropriate and effective services. Achieving diversity at all levels of the healthcare organization can change the way the organization serves the needs of workers of varying cultural and linguistic backgrounds (Anderson et al., 2003).

**Conceptual Models of Cultural Competency**

Models of cultural competency recognize the client’s cultural strengths, values, and practices while supporting behavior and attitude changes. They can be used to better understand the meaning of cultural competence. Three most widely used conceptual models include the Campinha-Bacote model, the Purnell model, and the Cross, Bazron, Dennis, and Isaac model.

**Campinha-Bacote Model**

One of the most well known conceptual models of cultural competency was developed by Dr. Josepha Campinha-Bacote (1994). She defined cultural competence as:

>a process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client/individual, or family or community. This process requires nurses to see themselves as becoming culturally competent rather than being culturally competent (Campinha-Bacote, 1994, p. 8).
Campinha-Bacote's model teaches nurses how to deliver culturally competent nursing care by using all its constructs in an educational program. It provides the framework and theory base for didactic nursing intervention. Campinha-Bacote's model uses a point of view based on one's own life's experiences. It encourages the client to be an educator of one's own culture and the health care provider to be a learner and learn the client's cultural beliefs. It also acknowledges that the health care provider's health outcomes should meet clients' cultural needs. In addition, it recognizes that culture is dynamic and has distinctions within a culture besides among different cultures.

Campinha-Bacote (1994) identifies five constructs to describe cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire.

- cultural awareness -- the process of conducting a self-examination of biases of other cultures and an in depth exploration of one’s cultural and professional background,
- cultural knowledge -- the process of seeking cultural information as well as biological variations among specific ethnic groups,
- cultural skill -- the ability to conduct a cultural assessment to collect relevant cultural data regarding client’s concerns as well as conducting a culturally-sensitive physical assessment,
- cultural encounter -- the process which encourages the counselor to directly engage in face-to-face cultural interactions in order to
modify their existing beliefs about a particular group to prevent stereotyping, and

- cultural desire -- the motivation to want to engage in the process of becoming culturally aware, knowledgeable, skillful, and capable of seeking cultural encounters.

Campinha-Bacote believes that cultural desire is the crucial construct of cultural competence that provides the foundation towards cultural competency. Health care professionals can work on any one of these constructs to improve the balance of all five constructs, but eventually all constructs must be experienced and addressed (HRSA, n.d.). Campinha-Bacote clarifies that the combination of the five constructs signifies the development of cultural competence (HRSA, n.d.).

**Purnell Model**

Another model of cultural competence was developed by Larry Purnell who defines cultural competence as the adaptive care that is consistent with the client's culture and is therefore a conscious process (Purnell, 2002). He identified 12 domains that make up the conceptual framework and described characteristics of culture which determine variations in values, beliefs, and practices of an individual's cultural heritage. These 12 domains include:

- communication,
- heritage,
- workforce issues,
• nutrition,
• family roles and organization,
• biocultural ecology,
• pregnancy and child bearing practices,
• high risk health behaviors,
• health care practices,
• health care practitioners,
• spirituality, and
• death rituals.

This conceptual model can be used to learn about different cultures. Purnell uses a guided development of assessment tools, planning strategies, and individualized interventions for nursing professionals to integrate cultural competence into their practice. Using the Purnell's Model for Cultural Competence, all health care professionals can perform cultural assessments of clients, their families, and communities from any cultural group encountered in practice, making it especially useful in today's multidisciplinary health care practice.

**Cross, Bazron, Dennis, and Isaac Model**

The Cross, Bazron, Dennis, and Isaac's model provides guidelines on how to gain cultural competence (Cross et al., 1989). The authors define cultural competence as:

a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable
that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, or religious group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates -- at all levels -- the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural difference, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs (Cross et al., 1989, pp. iv-v).

They explain that health care professionals must progress through six stages (cultural proficiency, cultural competence, cultural pre-competence, cultural blindness, cultural incapacity, and cultural destructiveness) in order to become skillful in cultural competency. Each stage is defined by an attitude and associated action or non-action. Cross et al. (1989) provide the following definitions:

- **cultural proficiency** -- engaging in research about cultural variety and differences,
- **cultural competence** -- accepting, appreciating, and accommodating cultural differences,
- **pre-competence** -- recognizing one’s own deficiencies in cultural
awareness, understanding the importance of cultural differences and awareness, and having the commitment to correct the deficiencies,

- cultural blindness -- stating that they are color blind and do not see color,
- cultural incapacity -- not accepting or responding to cultural diversity existing in a group, and
- cultural destructiveness -- relating to culture in an anti-cultural way through negative relationships with other cultures or attempting to eliminate them.

Several conditions must be present for health care professionals to progress along this continuum. Health care professionals must value diversity, understand their cultural biases, internalize cultural knowledge, be aware of the dynamics that may arise when culture interact, and acquire changes to diversity (HRSA, n.d.). All of these stages described by Cross et al. (1989) must operate at every level of the health care system to provide cultural competency in client care.

The model, however, has several weaknesses. One weakness is that it supports a prevailing view that practitioners and organizations have expert cultural knowledge of their workers (Brathwaite, 2003). This principle is unrealistic, since health care professionals do not have the expertise of every culture. Another weakness is that the model has not been used in real life situations but only used as a guide (Brathwaite,
National Standard for Cultural Competence

A national standard for cultural competence provides guidance for health care professionals, educators, administrators, policy makers, and advocates of cultural competency. It assists health care professionals to become aware of the depth and relevancy of cultural competence issues in providing quality, client-centered care and helps them to evaluate their own needs for education and training in these aspects of health care delivery (Gilbert, 2003). A national standard helps educators design curricula and activities that will provide a comprehensive background in the skills and knowledge of cultural competence. This would be useful for education of professionals who provide direct services to clients including medical school and residency programs and schools of nursing, social work, and public health (Gilbert, 2003). For health care administrators, a national standard could help them understand the need for quality education and training in cultural competence (Gilbert, 2003). It would guide policy makers in identifying requirements for cultural competence education for health care professionals. Lastly, a national standard promotes cultural competence as a specific standard of care expected of the health care professionals and organizations (Gilbert, 2003).

Department of Health and Human Services

Healthy People 2010 provides a framework for prevention for the United States. National health objectives identify the most significant
preventable threats to health and establish national goals to reduce these threats (United States Department of Health and Human Services [US DHHS], 2000). The premise of Healthy People 2010 is the health of the individual is interconnected to the health of the larger community, supporting the vision statement of “Healthy People in Healthy Communities” (US DHHS, 2000). Healthy People 2010 Goals include 1) increase quality and years of healthy life, and 2) eliminate health disparities.

Healthy People 2010 strives to increase life expectancy and quality of life over the next 10 years by helping individuals gain the knowledge, drive, and changes they need to make informed decisions about their health. At the same time, Healthy People 2010 encourages local and state leaders to launch local and statewide efforts that endorse healthy behaviors, make healthy environments, and increase access to high quality health care. All individuals need to be responsible for increasing their life expectancies and improving their quality of lives (US DHHS, 2000).

The second goal of Healthy People 2010 is to eliminate health disparities among segments of the population, regardless of gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation (US DHHS, 2000). Healthy People 2010 recognizes that organizations at all levels will need to take a multidisciplinary approach to achieving health equity -- an approach that involves improving health,
education, housing, labor, justice, transportation, agriculture, and the environment. US DHHS supports the principle that -- regardless of age, gender, race or ethnicity, income, education, geographic location, disability, and sexual orientation -- every person in the US deserves the same access to comprehensive, culturally competent, community-based health care systems serving the needs of the individual and promoting community health (US DHHS, 2000).

Individual health is associated with community and environmental health where individuals live, work, and play. Similarly, community health is influenced by the shared beliefs, attitudes, and behaviors of everyone who lives in a community. According to Healthy People 2010, the best way to reduce health disparities is to allow people to make their own informed health care decisions and promote community wide safety, education, and access to health care (US DHHS, 2000).

Institute of Medicine

The Institute of Medicine (IOM) issued a report that assesses cultural and ethnic differences in healthcare, evaluates possible sources of such differences, and provides recommendations regarding proper interventions (2003). The report recommends balancing access to high-quality insurance plans, strengthening provider-client relationships over time, increasing the number of minorities represented in the health professions, enforcing civil rights laws, and creating more interpretation services (IOM, 2003). One of the recommendations is to address and
resolve health disparities. It also recommends incorporating cross-cultural education into the training of all current and future health professionals (IOM, 2003).

Culturally and Linguistically Appropriate Services

The US DHHS Office of Minority Health issued the Culturally and Linguistically Appropriate Services (CLAS) national standards to ensure that all people entering the health care system receive adequate and effective treatment in a culturally and linguistically appropriate way (OMH, 2001). These CLAS standards address the current bias that exists in the health care industry and make health care services more accessible to the needs of all clients (See Appendix).

The standards 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 experience unequal access to health services (OMH, 2001, p. 3).

“Ultimately, the purpose of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans” (OMH, 2001, p. 1). While CLAS standards are primarily intended for health care organizations, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically available. The principles and activities of culturally and
linguistically appropriate services must be integrated into an organization and local communities being served (OMH, 2001).

National Association of Social Workers

The National Association Social Workers [NASW] (2001) established Standards for Cultural Competence to guide social workers in responding effectively to the diversity of clients and communities in which they work. These standards offer guidelines, goals, and objectives for the future of social work and occupational health practice. The goals of the standards are to:

- maintain and improve the quality of culturally competent services provided by social workers, and programs delivered by social service agencies,
- establish professional expectations so social workers can monitor and evaluate their culturally competent practice,
- provide a framework for social workers to assess culturally competent practice,
- inform consumers, governmental regulatory bodies, and others, such as insurance carriers, about the profession's standards for culturally competent practice,
- establish specific ethical guidelines for culturally competent social work practice in agency or private practice settings, and
• provide documentation of professional expectations for agencies, peer review committees, state regulatory bodies, insurance carriers, and others (NASW, 2001, p. 14).

Achievement of cultural competency requires the awareness, commitment, and contribution of individuals (Diaz, 2002).
Cultural Competence 31

CHAPTER 3
APPROACHES TO INCREASE CULTURAL COMPETENCE IN THE
OCCUPATIONAL HEALTH CARE WORKFORCE

Principles Guiding Cultural Competence

Seven basic principles guide occupational health care professionals toward cultural competence. They include defining culture broadly, valuing clients' cultural beliefs, recognizing complexity in language interpretation, facilitating learning between providers and communities, involving the community in defining and addressing service needs, collaborating with other agencies, professionalizing staff hiring and training, and institutionalizing cultural competence (HRSA, 2001). These principles can be applied in any work setting to achieve cultural competence.

Defining Culture Broadly

Most individuals interpret culture as something that distinguishes diverse groups of people. Race and language are often associated with a specific culture, resulting in the use of the following categories by the Census Bureau, for example: Hispanic, African American, Asian American and Pacific Islanders (HRSA, 2001). Understanding how clients access health care services is an essential part of providing culturally competent care (HRSA, 2001). "Cultural competence is demonstrated not only by knowledge of cultural groups represented, but also through an abundance
of practical and experience-based knowledge about the community being served" (HRSA, 2001, p. 13).

**Valuing Clients’ Cultural Beliefs**

Valuing clients’ cultural beliefs is another way in which cultural competence is demonstrated. Occupational health professionals must learn and value the cultures and beliefs they serve. Cultural competence can be shown by using information from the local population to improve access to and quality of care while respecting cultural health beliefs and practices (HRSA, 2001).

**Recognizing Complexity in Language Interpretation**

Communication is more than shared language. Being able to speak a client’s language is essential, but it does not always guarantee effective communication between the client and the provider. It must also include a shared understanding and a shared perspective (HRSA, 2001). A key principle is knowing the complexity of language interpretation.

Three concepts must be considered when providing culturally and linguistically appropriate health care: “recognizing the linguistic variation within a cultural group, recognizing the cultural variation within a language group, and recognizing the variation in literacy levels in all language groups” (HRSA, 2001, p. 16). In order to be familiar with the linguistic variation and cultural groups, health care providers “…need to use multiple strategies to meet their [clients’] language needs (HRSA, 2001, p. 2). For example, telephone interpreter services are used by
organizations when clients speak a variety of different languages. Examples of recognizing the variation in literacy levels are "...programs, particularly those providing health care and services to migrant and seasonal farmworker communities address not only language and race/ethnicity, but also literacy, since some individuals may not be literate in their native language" (HRSA, 2001, p. 17).

**Facilitating Learning Between Providers and Communities**

Creating environments where learning can occur is crucial to improving the health of both individuals and communities. Health care providers need to learn more about the cultural framework, knowledge, beliefs, and attitudes of the communities they serve. Communities need to learn more about how the health care delivery system works. "Both need to learn how collaboration between providers and communities will improve access and quality of care through improved cultural competence" (HRSA, 2001, p. 17).

**Involving the Community**

Another principle is to involve the community in defining and addressing service needs. Cultural competence means more than client satisfaction with services that only minimally meet the cultural or linguistic needs of the target community. Programs that are truly culturally competent involve workers and community members in identifying community needs, assets, and barriers, and in creating appropriate program
responses. In this approach, clients and community members play an active role in needs assessment, program development, implementation, and evaluation. Some organizations institutionalize this relationship by making individuals from the community voting members of their governing boards. Others facilitate input and recommendations by using community advisory boards, client panels, task forces, or town meetings. Still others sponsor locally based community research (interviews, focus groups, etc), and integrate the results into program design. Some programs integrate clients and community members ... by using volunteers from the target community in a variety of program areas, serving as peer advocates who help new clients negotiate the [healthcare] system (HRSA, 2001, p. 19).

For example, in some communities, local community members work at local health care agencies to facilitate communication and assist clients to feel more comfortable going through the health care process (HRSA, 2001).

Collaborating with Other Agencies

Several community organizations have been proactive in expanding culturally competent services by combining forces with other local agencies and organizations. Some organizations have built strong collaborative relationships with medical school residency programs and described the benefits of these staffing arrangements to the provision of
culturally competent care (HRSA, 2001). For example, the Family Healthcare Center in Fargo, North Dakota is a program serving migrant and seasonal farmworkers and a large number of recent refugees from all over the world. Family practice residents work at the ambulatory care clinic during their three year residency training. The residency program actively recruits minority residents, including Native American, East Indian, Russian, South American, and Asian residents. This collaboration between the Family Healthcare Center and the residency program enables family practice residents to train in a culturally diverse environment, which will better prepare them for a culturally competent practice in family medicine (HRSA, 2001).

**Hiring and Training Staff**

Hiring and training skilled staff is also important. Organizations are establishing specific hiring qualifications and mandated training requirements for all staff in language, medical interpretation, and cultural competence (HRSA, 2001). The Family Healthcare Center has been successful in setting up training facilities in their area and using them for their own staff, as well as training other organizations in cultural competency. They are also developing comprehensive training curriculum for the staff. The importance of using a training curriculum that can be customized to the issues of specific cultures and local communities is necessary to guide health care professionals towards cultural competence (HRSA, 2001). “Allocating for budget and time for staff training including
training new staff, annual updates and review..." is another way that organizations hire and train staff (HRSA, 2001, p. 23).

Institutionalizing Cultural Competence

Institutionalizing cultural competence is the last key principle. One way to instill cultural competence is by integrating it into planning, goals, and protocols of an organization (HRSA, 2001). Incorporating values on diversity and cultural competence allows employers and employees to see that their organization is committed to achieving certain levels of quality improvement and cultural competence for everyone. Another way to make sure cultural competence is practiced is to have staffing and culturally competent activities well-funded. Designing culturally competent activities for other cultural groups and for other health care programs is also advantageous (HRSA, 2001). Employers need to invest in culturally-sensitive worker training and adjust to the needs of all workers (Amurao, 2004).

Techniques for Cultural Competence

There is no universally effective approach to building cultural competence or creating a culturally competent workplace. However, techniques most frequently discussed in the cultural competence literature include:

- providing interpreter services,
- developing recruitment and retention policies for agencies/companies,
- coordinating with traditional healers/ formulate treatment plans which take into account cultural beliefs and practices,
- involving community representatives in the health care organization's planning and quality improvement meetings, and
- offering culturally competent health promotion, and including family/community members (Brach & Fras erdirector, 2000, pp.185-187).

**Interpreter Services**

Providing interpreter services to workers is very important since they should be able to understand the nature and purpose of their work and lifestyle along with the healthcare services they receive. Accurate and timely communication between provider and worker increases the likelihood of workers receiving appropriate treatment (Diversity Rx, 2000). Language ability varies between individuals. For example, a person may understand enough English to complete a form but may need considerable help to understand diagnosis and treatment options for a condition. An English-speaking provider may know basic vocabulary or medical terminology in the worker’s language but may lack understanding of the cultural nuances that affect the meaning of words or phrases. In the health care setting, non English-speaking clients can be assisted by family members, staff members who act as interpreters, or by professionally trained interpreters-whose training in medical terminology and
confidentiality may both prevent communication errors and protect privacy (Anderson et al., 2003).

Another suggestion is to provide clients with Limited English Proficiency (LEP) access to bilingual staff or interpretation services, especially to those who cannot speak English (Fortier, Convissor, & Pacheco, n.d.). In addition, written materials, such as signs provided to clients in their primary language, inform them of their right to receive interpreter services free of charge (Fortier et al., n.d.). Interpreters and bilingual staff must demonstrate bilingual proficiency. Their training should include the skills and ethics of interpreting and the knowledge of both languages using clinical and laymen terms and concepts (Fortier et al., n.d.).

**Recruitment and Retention Policies**

Developing recruitment and retention policies for agencies and companies is very important. Due to common cultural beliefs, minority health care providers can improve communication, create a more welcoming environment, and structure health care to better reflect the needs of minority work population (Brach & Fraserrictor, 2000). Workforce diversity in the healthcare setting is seen as a way of providing relevant and effective services. Achieving diversity at all levels of the healthcare organization can influence the way the organization serves the needs of clients of various cultural and linguistic backgrounds (Anderson et al., 2003).
Traditional Healers

Another helpful technique is using traditional healers to formulate treatment plans which take into account cultural beliefs and practices (Brach & Fraserirector, 2000). Traditional healers may function as a substitute for a small proportion of clients, but in most cases, they are used in combination with the conventional health care providers (Brach & Fraserirector, 2000). Occupational health care providers need to coordinate with these healers as they would with any other health care provider whom a patient is seeing to ensure continuity of care and avoid problems due to incompatible therapies. Also, providing patient education and treatment regimens similar to cultural beliefs and traditional health practices may increase the chances that clients will agree with and adhere to treatment recommendations (Brach & Fraserirector, 2000).

Community Representative Involvement

Along with traditional healers, community representatives should be formally or informally involved in the health care organization’s planning and quality improvement activities. Minority community members are used to reach out to other community members as well as to provide direct health care education and primary care (Brach & Fraserirector, 2000). These liaisons, who are known and respected by the local community, assist in directing the local health system, thereby providing cost effective health care services to isolated communities that once lacked access to health care. Local community members are aware of the
cultural differences between health care providers and the local clientele, and most minority clients may believe in Western medicine in addition to traditional methods (AMSA, 2004).

**Culturally Competent Health Promotion**

Offering culturally competent health promotion is another useful technique. Culturally competent health promotion implies the merging of culturally sensitive concepts and practices into health promotion activities (Fortier & Bishop, 2003). Cultural competence can also increase the value of health promotion activities for racial and ethnic minority groups. Health promotion activities can be modestly successful in reducing harmful behaviors -- such as smoking, excessive consumption of alcohol, and poor diet (Brach & Fraser, 2000). Examples of healthy practices are risk reduction, early detection and treatment, and proper care of chronic or acute diseases.

In an attempt to make health promotion efforts more culturally competent, culture-specific attitudes and values have been incorporated into public health messages and materials (Brach & Fraser, 2000). For example, Kaiser Permanente in San Francisco, California has created a department of multicultural services that provides on-site interpreters for clients in all languages. There is also a special translation unit that makes sure all written materials and signs are translated (Betancourt et al., 2002).
Inclusion of Family/Community Members

Involving families is crucial in obtaining consent for treatment and adherence to care of clients. Some minority groups believe that family members should be involved in health care decision making. For example, Mexican Americans are more likely than European or African Americans to have family members make treatment decisions, instead of the client (Brach & Fraserirector, 2000). Through the process of family involvement, important cultural issues that affect health care service delivery and utilization can be identified by families and result in healthier outcomes (Fortier & Bishop, 2003).

Benefits of Cultural Competence in the Occupational Health Care Workforce

The occupational health care workforce benefits from cultural competence. Racial and ethnic minority health care providers are more likely to serve minority and medically underserved communities, thereby increasing access to care for these populations. Also, racial and ethnic minority clients report greater levels of satisfaction of care provided by minority health professionals. It is less likely that minority health professionals will practice racial or ethnic discrimination (Brach & Fraserirector, 2000). A more diverse workforce may help ensure that minority populations receive care in settings they trust and in ways that respect cultural values and beliefs. Minority clients who see minority health care professionals have claimed to have better communication,
greater satisfaction with care, and greater use of preventive services
(Grantmakers in Health, 2001).

Cultural competence also benefits the clients. These benefits include:

- the health care provider can obtain more specific and complete information to make a more accurate diagnosis,
- appropriate treatment plans can be developed to facilitate return to work,
- delays in seeking care are reduced and health care services can be used,
- communication between clients and health care providers is enhanced, and
- Western health practices are integrated into traditional cultural health practices (HRSA, 2001).

Overall, providing culturally competent health care services contributes to increased productivity for workers and their companies.

When cultural competence is not addressed, health care may be compromised. The development of cultural competence must occur beyond the level of the individual provider to include local, state, and federal health care agencies. “All health care programs must measure their level of cultural competence and devise strategies for achieving broad based cultural inclusion if equality in health care is to be attained” (Randall, 1999, Chapter 2, last ¶).
CHAPTER 4
CULTURAL COMPETENCE AND OCCUPATIONAL HEALTH PROFESSIONALS

Almost 20% of the US labor force comes from minority groups. Foreign-born workers 16 years and older accounted for 48.6% of the total labor force from 1996 to 2000 (See Table 4.1). According to Loh and Richardson (2004), these workers logged a 43% increase in fatal occupational injuries compared to the 5% decline seen in all US workers during that same time period, as shown in Table 4.2 and Figure 4.1. This increase in fatal occupational injuries among minority workers, along with the decline in fatalities in the general workforce, shows that minority worker health and safety lags behind that of other workers (Amurao, 2004). "Disparities have been attributed to a disproportionate representation of immigrants in occupations and industries that carry higher risks of injury and fatality, coupled with the workers' lower levels of education and lack of English proficiency" (Amurao, 2004, p. 9). These statistics show the importance of occupational health care professionals providing culturally competent care for their organizations and communities.

Occupational health professionals must be aware of ethnic and cultural differences in the implementation of occupational health and safety programs. Ideally occupational health and safety professionals should reflect the social make-up and diversity they serve (IOM, 2000).
### TABLE 4.1
FOREIGN BORN AS PERCENT OF LABOR FORCE CHANGE BY SELECTED DEMOGRAPHIC CHARACTERISTICS, ANNUAL AVERAGES 1996–2000

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total Labor Force Change</th>
<th>Foreign Born Labor Force Change</th>
<th>Change in Foreign Born As Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age and Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total, 16 years and</td>
<td>6,733</td>
<td>3,272</td>
<td>49</td>
</tr>
<tr>
<td>older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>3,062</td>
<td>1,925</td>
<td>63</td>
</tr>
<tr>
<td>Women</td>
<td>3,671</td>
<td>1,348</td>
<td>37</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, non Hispanic</td>
<td>1,940</td>
<td>542</td>
<td>28</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>1,290</td>
<td>366</td>
<td>28</td>
</tr>
<tr>
<td>Asian, non-Hispanic</td>
<td>819</td>
<td>683</td>
<td>83</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2,566</td>
<td>1,661</td>
<td>65</td>
</tr>
</tbody>
</table>

(Numbers in thousands)

Source: Mosisa, 2002
TABLE 4.2
FATAL OCCUPATIONAL INJURIES IN THE UNITED STATES, 1996-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>All Workers</th>
<th>Native-born</th>
<th>Foreign-born</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>6,202</td>
<td>5,474</td>
<td>728</td>
</tr>
<tr>
<td>1997</td>
<td>6,238</td>
<td>5,523</td>
<td>715</td>
</tr>
<tr>
<td>1998</td>
<td>6,055</td>
<td>5,402</td>
<td>653</td>
</tr>
<tr>
<td>1999</td>
<td>6,054</td>
<td>5,244</td>
<td>810</td>
</tr>
<tr>
<td>2000</td>
<td>5,920</td>
<td>5,069</td>
<td>851</td>
</tr>
<tr>
<td>2001</td>
<td>5,915</td>
<td>4,921</td>
<td>994</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36,384</td>
<td>31,633</td>
<td>4,751</td>
</tr>
</tbody>
</table>

FIGURE 4.1

FATALITY RATE OF UNITED STATES WORKERS BY NATIVITY,

1996-2001

Source: Loh & Richardson, 2004
Recruitment of occupational health professionals should include all racial and ethnic groups. To enhance cultural competence, training should include changes in the physical and cognitive abilities of older workers, the interaction of chronic diseases and disabilities with workplace demands, and communication skills needed to reach minority workers, workers with low levels of literacy, and those for whom English is a second language (IOM, 2000).

Healthcare facilities, such as primary care clinics, occupational health clinics, and hospitals encounter diversity every day. The need for culturally and linguistically competent health care services for diverse populations is attracting increased attention from health care providers. Knowing that each individual is a unique, psycho-social, cultural being and that scientific knowledge goes hand-in-hand with socio-cultural skills are imperative in providing culturally competent services (Amurao, 2004).

While some health care providers have delivered appropriate services to diverse populations for many years, this has not been the case in most occupational health care settings. Occupational health care professionals begin to treat more diverse clients based on demographic changes and participation in insurance programs, interest in designing culturally and linguistically appropriate services that lead to improved outcomes, efficiency, and satisfaction has increased (Fortier et al., n.d.).
Role of Interdisciplinary Occupational Health Team

The interdisciplinary occupational health team works together to provide a safe and healthy work environment for all workers. Each member has a different role and brings varying backgrounds, experience, and expertise. Through collaboration, they can maintain, protect, and improve the health and safety of the worker.

Cultural competent training programs for the occupational health team -- physicians, nurses, industrial hygienists, and safety professionals-- have several goals. They are designed to enhance self-awareness of attitudes toward minority group members, increase knowledge about minority populations, and improve specific skills such as communication (Brach & Fraserirector, 2000). Training provides a way to improve cultural differences that stem from a misunderstanding of each other’s health beliefs. People may be culturally competent in serving members similar to themselves but not serving others. The diversity within racial and ethnic groups make culturally competent training appropriate for all occupational health professionals, including members of minority groups (Brach & Fraserirector, 2000).

Individuals' and Communities' Characteristics and Needs

The occupational health team works towards cultural competence at the worksite by responding to the workers' characteristics and needs. The occupational health team can improve communication skills by interviewing and assessing workers in their own native language or via
appropriate use of a bilingual/bicultural interpreter. Another method is to use a reflective approach by examining one's own biases and expectations to understand how to influence interactions and decision making. The occupational health professionals should ask questions to increase understanding of the workers' cultures as it relates to health care and safety practices. For example, asking if they use Western medicine may facilitate treatment for their illness/injuries. Other methods include providing clear communication expectation by speaking slowly and not loudly. Translating information into the worker's native language is also useful. The occupational health team should make use of drawings and gestures to promote communication when appropriate. Written instructions or handouts are useful if available.

In addition to these communication techniques, occupational health professionals must develop negotiation skills. A good negotiator understands the needs of workers, tries to meet those needs without losing sight of his/her own goals, and finds mutual agreement for everyone involved (Association for the Study of Medical Education [ASME], 2004). Unresolved conflict is detrimental to workers and occupational health professionals (ASME, 2004). The impact of unresolved conflict between workers and occupational health professionals include:

- wasting worker productivity,
- increasing worker turnover,
- lowering worker morale,
increasing worker stress which may lead to illness (ASME, 2004).

There are other benefits of acquiring good negotiation skills. The ability to resolve conflict can boost career growth. When viewed as a leader, occupational health professionals become influential in their organization and increase their professional credibility. On the personal level, good negotiation skills can enhance relationships and create less anxiety and stress at the workplace (AMSE, 2004).

**Issues of Bias at the Worksite**

Along with communication techniques and negotiation skills, the occupational health team must address with issues of bias at the worksite. According to the University of California Regents (2004), occupational health professionals should have these skills to handle cultural/ethnic biases, including:

- an understanding and acceptance of diversity concepts,
- a self-awareness of one’s own culture, identity, biases, prejudices, and stereotypes, and
- a willingness to challenge and change institutional practices that present barriers to different groups (University of California Regents, 2004, Your Role section, ¶ 1).

**Trust with Communities**

Building trust with communities is also important. Trust can be developed by working on other social needs besides health, providing
language and other services important to workers in the community, and utilizing community resources effectively.

Occupational health professionals should hire a bilingual/bicultural occupational health staff who can provide culturally competent care to workers. By incorporating cultural competence into their practice, occupational health professions can meet worker health needs (McDonald, 2001).

**Roles of the Occupational and Environmental Health Nurse**

Occupational and environmental health nurses (OEHNs) assume important roles to integrate cultural competency in their agencies. They must conduct initial and ongoing organizational assessments of CLAS-related activities and integrate cultural and linguistic competence-related measures into their practice.

OEHNs assess the workforce to determine demographic and educational levels. They must also orient and train workers, managers, supervisors, and other occupational health team members about different cultures that are present at the worksite. This training aims to:

- increase one’s sensitivity and awareness,
- provide multicultural health and demographic information about the local community area,
- build skills in bicultural/bilingual interviewing,
- enhance the use of race or ethnic-specific epidemiological data in diagnosis and treatment, and
• increase cultural knowledge and understanding (Fortier & Bishop, 2003).

It is believed that the knowledge and skills gained through training will enable providers and organizations to work more effectively in cross-cultural situations by developing new approaches to communication, worker health, and service planning that is based on cultural and linguistic needs (Fortier & Bishop, 2003, p. 19).

Increasing communication and sensitivity are also important for OEHNs. They improve cultural competence at the worksite by using interpreters, learning key words in other languages, and developing and translating health education material into other languages. “Culturally and linguistically appropriate health education materials are designed to take into account differences in language and nonverbal communication patterns and to be sensitive to cultural beliefs and practices” (Anderson et al., 2003, p. 74).

Occupational and environmental health nurses need to promote a respectful and inclusive work atmosphere. They must develop an awareness and understanding of individual differences among their employees (Washington Department of Health Multicultural Work Group [WDHMW], 2001). They must appreciate these differences and accept and respect all employees as they all work together. OEHNs must also assure optimal health for their communities by promoting an atmosphere within the organization that encourages employees to recognize
themselves as individuals, meeting the health needs of workers with different health beliefs and norms, and creating a system that allows for creative and flexible solutions to meet these health needs (WDHMW, 2001).

There are many future challenges for OEHNs as they integrate cultural competence into their nursing practice. It is imperative that they stay current in the areas of nursing, occupational health, environmental health, and safety. This requires coordinating and collaborating with professionals in other health and safety disciples as well as frequent interaction with all workers.

Occupational and environmental health nurses need to provide programs that take into account varying literacy levels while implementing culturally competent job and safety training. A number of national and state organizations in the US have identified that a Level 3 proficiency in literacy is the minimum standard for success in today's labor market (Sum, Kirsch, & Taggart, 2002). Level 3 is the minimum desirable level of literacy proficiency. At this level, workers "...can use the reading strategies of skimming, scanning, and predicting to locate information and to help structure their reading for a variety of purposes" (ACT, 2005, Level 3 section, ¶ 2). They "...typically can comprehend prose of several paragraphs on subjects within a familiar framework and with a clear underlying structure, and they can understand some main ideas in limited occupational or academic materials" (ACT, 2005, Level 3 section, ¶ 1).
Findings from the International Adult Literacy Survey indicate that only half of the US adult population 16-65 years of age reached Level 3 proficiency (Sum et al., 2002). Methods employed to assess literacy levels include the use of screening instruments that test for certain skills related to functional literacy or less formal tools that allow health care professionals to determine an individual's comfort level with various types of communication. For example, at the To Help Everyone Clinic (THE) in Los Angeles, health care professionals speak individually with clients when they arrive at the health clinic to determine whether the clients prefer to learn by using written materials, pictures, verbal counseling, or some other technique. This method of assessment allows the clients to identify their own learning style preference without having to take a literacy test. This technique also reduces feelings of fear or humiliation that may occur (Kiefer, 2001).

Limited literacy of an organization's workforce is a significant barrier to productivity, health, and safety. Workers with limited literacy skills have poorer job performance, are more likely to damage equipment, and sustain more work-related injuries due in part to an inability to read warnings, safety manuals, or instructions (Amurao, 2004).

To address the needs of all workers, occupational health nurses must understand that cultural competence does not mean substituting one's own cultural identity with another, ignoring the variability within cultural groups, or even knowing everything about
the cultures being served. In its place, an admiration for difference, an enthusiasm to learn, and a motivation to recognize that there are many ways of viewing the world will distinguish nurses who integrate cultural competence into their daily practice from those who merely understand it (Gonzalez, Gooden, & Porter, 2000, Fostering Cross-Cultural Competence section, ¶ 2).
CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

Policy Implications

Many of the current efforts in occupational health and social services lack the values, policies, and organizational structures that support culturally competent practices at both the institutional and community levels. Policy makers need to put into practice the efforts to change organizations, enhance quality of services and access to primary care, and improve outcomes for racially and ethnically diverse groups. These efforts can help eliminate racial and ethnic disparities in health care (Cohen & Goode, 1999). Policies on cultural competence must exist at all levels, from the organization's top management to clinicians to administrative staff. Organizational policies that address language and literacy barriers are the most successful (Center on an Aging Society, n.d.).

Public Health Implications

Local, state, and federal agencies need to expand the collection and reporting of health data that include information on race, ethnicity, and primary language (Fortier et al., n.d.). Data collection on cultural needs, resources, and assets of an organization's surrounding community are useful in planning and implementing community-based ethnic organizations. Occupational health care providers can use these
resources to assist with outreach and health care delivery to diverse ethnic groups (Fortier et al., n.d.).

The second public health implication is to raise public awareness that data collection is needed to achieve Healthy People 2010 goals -- specifically occupational health and safety objectives -- and to comply with Title VI nondiscrimination requirement. Culturally competent health care is integral to achieving the goals of Healthy People 2010. Barriers to accessing health care services include cultural differences, language barriers, and discrimination. Providing culturally competent health services improves all focus areas of Healthy People 2010 by reducing barriers to accessing clinical preventive care, primary care, emergency services, and long-term care (Anderson et al., 2003).

**Research Implications**

Although some analysis has shown that a lack of attention to cultural and linguistic issues is associated with less optimal health care, research has not yet fully explained the relationship between culturally and linguistically competent health services and clinical outcomes/health status. Further research is needed to determine where ethnic populations at risk are working, the conditions of the work environment, and the extent and severity of disease and injury among these workers.

Research is conducted in a manner that reinforces collaboration between the community and research institutions. Relevant results are disseminated to the community in clear and useful terms.
Moreover, these studies are designed to be culturally appropriate—for example, consideration is given to the social, economic, and cultural conditions that influence health status. Identifying and incorporating unique cultural factors into intervention strategies may result in increased acceptability, use, and adherence. This approach seeks to maximize the potential for change in knowledge, attitudes, and behavior (National Institute of Environmental Health Sciences [NIEHS], 2001, ¶ 3).

As policymakers, academicians, and occupational health care providers begin to support health services that are culturally and linguistically appropriate, questions inevitably arise about the intrinsic and relative value of different approaches, methods, and programs (Diversity Rx, 2001). The National Institute for Occupational Safety and Health (NIOSH) has developed a research agenda that includes low income, immigrant, and minority workers in an effort to build on the initiatives undertaken by other parts of the Center for Disease Control (CDC) and other health researchers. The main goal of the agenda is to develop a better research base to address the well-documented health disparities among racial and ethnic minority populations in the US. NIOSH has already collaborated with researchers around the country to better coordinate and compare data on diverse low income immigrant and minority working populations (NIOSH, n.d.). It is necessary to facilitate the development of a health services research agenda on cultural
competence in health care. The areas that need to be addressed are access and outcomes, quality and reduction in error and cost, and comparative analyses.

Research on access and outcomes needs to be conducted. Ways to pursue further research on cultural competence interventions depend on the kinds of questions stakeholders want answered (Fortier & Bishop, 2003). Studies need to be conducted on how interpreter services may improve the way clients maneuver through a health care program/agency. Data need to be collected to see which interventions increase access for the culturally and linguistically diverse populations and to improve health outcomes for these populations.

Research on the quality of cultural and linguistic interventions also needs to be evaluated. Studies that investigate what type of cultural competence training is needed to improve client and provider interaction should also be included in the research. Collection of data in this area of research is helpful to assist occupational health care agencies and programs to funnel resources to appropriate cultural and linguistic interventions.

Cost effectiveness also needs to be evaluated. Researchers need to know which interventions are cost effective -- for example, reduce diagnostic testing and emergency room use or increase preventive services to lower future health costs. Cost effectiveness is very important since funding for resources is always limited.
Lastly, comparative analyses need to be prepared. Since there is a lack of knowledge about the training needs of the current health care workforce, research needs to be conducted that examines numerous areas, including:

- current training regarding worker health available in health professions schools,
- gaps in cultural competence in current minority health staff,
- employment performance standards for minority health employees, and
- mechanisms and models needed for inclusion of former immigrants in the health care workforce (McDonald, 2001, p. 49).

With input from a research advisory committee and the public, Resources for Cross Cultural Health Care (RCCHC) will develop a research agenda intended to examine the research base underlying the field of CLAS in health care, identify issues associated with conducting research in this field, and suggest approaches for developing and implementing a CLAS research agenda. The final document is intended to be a guide for researchers and stakeholders interested in cultural competence (Diversity Rx, 2001).

Research on cultural competence has begun and is of growing interest to the occupational health care services research community. Much more work is needed to raise the awareness about the existing
evidence based on cultural competence interventions and to promote continued research on this issue (Fortier & Bishop, 2003). Research shows that both structural and cultural barriers exist to shape access, use, and approval of services. Nevertheless, additional investigation needs to be done on the usefulness of various methods and approaches (Administration on Aging, 2001).

**Health Care Practice Implications**

As cultural diversity continues to expand, academic training of cultural competence has not been regularly offered or institutionalized in many health care fields. Racial and ethnic minority groups with diverse concepts of illness and health care are coming to clinics and hospitals, making it more and more imperative that health care professionals obtain new knowledge and competencies to meet their clients' health needs (Gilbert, 2003).

**Incorporating Cultural Competence**

Cultural competence should be incorporated into academic and health care practice including all health professions schools. By making cultural competence training a requirement in the health care provider curriculum, the health care workforce will be improved. Within the required course, specifics of worker health and welfare can be explored and can increase the global viewpoint of occupational health care professionals (McDonald, 2001).
Improving Admissions Policies and Practices

Improving admissions policies and practices in academic institutions is also imperative. Dr. Bristow believes that diversity in health professions schools can be enhanced by increasing the numbers of minority students who enroll and graduate from health professions schools and by Congress assisting and providing increased funding for such programs (Smedley, Stith, & Bristow, 2004).

Health care professionals who are racial and ethnic minorities are significantly more likely than their white peers to serve minority and medically underserved communities, thereby helping to improve problems of limited minority access to care. For example, minority physicians, dentists, nurses, and psychologists are more likely than non minority health professionals to treat patients of color, indigent patients, and patients who have greater health challenges. Greater diversity among health professionals is also associated with higher satisfaction with care among minority patients. Minority patients who have a choice are more likely to select health care professionals of their own racial or ethnic background, and generally rate the quality of their health care as higher than in racially discordant settings. Diversity in health professions training settings may help to improve the cross-cultural training and cultural competencies of all trainees. Interaction among students from
diverse backgrounds helps them to challenge assumptions and broaden their perspectives regarding racial, ethnic, and cultural differences. In addition, there is growing evidence that campus diversity experiences are associated with gains in all students' learning outcomes and community involvement (Smedley et al., 2004, ¶ 7-8).

Benefits of increasing the diversity of the health care workforce include:

- increased employees' respect for diversity,
- enhanced an agency's reputation as an employer who supports diversity,
- strengthened an agency's responsibility,
- enhanced productivity,
- kept pace with technologic change,
- expanded options for problem-solving,
- improved communication at all levels,
- maximized effectiveness of their operations, and utilized human resources more effectively (Koplan, 2001).

Cultural diversity among health professionals benefits everyone.

**Funding to Expand Health Care Services to Communities**

Funds are needed to expand the number of minority health professionals to provide culturally competent, linguistically appropriate health care services to communities. State and local governments should increase funding for diversity efforts through programs such as tuition
reimbursement, loan repayment, and other efforts. Additionally, private agencies should also be encouraged to join forces with business partnerships with academic institutions to assist in developing a more diverse health care workforce (Smedley et al., 2004).

Including Guidance on Training Methods and Evaluation

Cultural competence should also be included in training methods, evaluation, and qualifications of educators. The development of curriculum standards and evaluation tools can help organizations determine which training programs are most likely to promote cultural competence among their providers and staff (OMH, 2001).

Assisting Health Professionals on Culturally Appropriate Education

Another implication is assisting health professionals to provide culturally appropriate education. Culturally and linguistically appropriate health education materials are designed to take into account differences in language and nonverbal communication patterns and to be sensitive to cultural beliefs and practices (Anderson et al., 2003). Encouraging diversity efforts through accreditation of schools and hospitals is another academic implication. Smedley & Sabol (2004) suggested that academic institutions should:

- create and enforce diversity-related standards,
• acquire clear policies conveying the value and significance of culturally competent health care and the responsibility for racial and ethnic diversity in achieving this objective,
• develop standards and criteria that encourage and support underrepresented minority student and faculty participation,
• include criteria and standards to assess the success of diversity efforts,
• include underrepresented minority students and other individuals with knowledge in cultural competence and diversity on accreditation bodies and advisory groups, and
• apply restrictions if diversity related standards are not met.

Certification/Training/Continuing Education

Certification/training/continuing education for occupational health professionals is also needed. Cultural competency training is designed to enhance self-awareness of attitudes toward people of different racial and ethnic groups. Occupational and environmental health nurses have increased knowledge about the cultural beliefs and practices, attitudes toward health care, health care seeking behaviors, and the burden of various diseases in different populations being served (Anderson et al., 2003). Communication skills are also improved in cultural competence training. Currently, cultural competence training and education in academic settings differ, ranging from semester-long courses to a few hours of training. Collaboration among agencies, health professions
Cultural competence schools, state licensure bodies, and accreditation agencies can help ensure that cultural competency training is integrated into all phases of health professions education, including core curriculum, professional licensure, and continuing professional development programs (OMH, 2001).

The American Association of Occupational Health Nurses (AAOHN) has identified the need for continuing education on cultural competence. By offering the course on-line, it will enable more occupational and environmental health nurses to attend and thus decrease health disparities and improve the well being of culturally diverse workers and their organizations. As a result occupational and environmental health nurses can effectively provide services to an ever-changing workforce (American Association of Occupational Health Nurses, 2005).

Occupational health care professionals can independently learn cultural competence skills. The OMH recommends that practitioners read *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* (California Endowment, 2003) as it provides a general overview on cultural competence. Also, occupational health care professionals can become culturally competent by enrolling in and completing a Competence Certificate Program offered by local Community Area Health Education Centers in most states. The Bureau of Primary Health Care (BPHC) is an excellent online resource for cultural competency. There are self-study modules on cultural competency.
available for professionals. Cultural competence activities include the development of skills through training, use of self-assessment tools for providers and systems, and implementation of objectives to ensure that governance, administrative policies and practices, and clinical skills and practices are responsive to the culture and diversity within the populations served. It is a process of continuous quality improvement (CEO Services, 2001).

**Future Outlook**

Prevention is seen as an investment. Healthy workers are more productive and take less medical leave (Center on an Aging Society, n.d.). Healthy elders live longer and need fewer health care resources. Eliminating racial and ethnic health disparities and improving the health of all Americans is the ultimate goal of Healthy People 2010. Compelling evidence shows that race and ethnicity correlate with persistent, and often increasing, health disparities (Administration on Aging, 2001). Reducing these disparities is one of the major challenges facing the entire health care industry.

Occupational and environmental health nurses must be knowledgeable about current health care issues to provide adequate health care services to workers in their facilities. In addition, an increasing body of research indicates that culturally and linguistically appropriate services leads to improved health outcomes, increased beneficiary satisfaction, and organizational efficiencies that result in decreased
spending. Cultural competence is not an isolated aspect of health care, but an important component of overall excellence in health care delivery. Efforts to improve cultural competence among health care professionals and organizations contribute to improving the quality of health care for all clients.
REFERENCES


APPENDIX

NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Preamble (excerpt)
The following national standards issued by the US Department of Health and Human Services’ Office of Minority Health respond to the need to ensure that all people entering the healthcare system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients or consumers. The standards 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 experience unequal access to health services. Ultimately, 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.

Culturally competent care
Standard 1. Healthcare organizations should ensure that patients or consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Healthcare organizations should ensure that staff members at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language access services
Standard 4. Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient or consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Healthcare organizations must provide to patients or consumers in their preferred language both verbal offers and written
notices informing them of their right to receive language assistance services.

Standard 6. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff members. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer).

Standard 7. Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.

**Organizational supports for cultural competence**

Standard 8. Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability or oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Healthcare organizations should ensure that data on the individual patient’s or consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated.

Standard 11. Healthcare organizations should maintain a current demographic, cultural, and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Healthcare organizations should develop participatory, collaborative partnerships with communities and use a variety of formal and informal mechanisms to facilitate community and patient or consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients or consumers.
Standard 14. Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Source: Office of Minority Health, 2001