The Culturally Competent Leader

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LEARNING OBJECTIVES

By the end of this chapter, the student will be able to:

· Describe the effects of changing demographics and population trends on healthcare organizations.
· Define and distinguish between diversity, diversity management, cultural competence, healthcare disparities, and health disparities.
· Discuss the value of cultural competence in healthcare organizations.
· Present leadership strategies that promote cultural competence.
· Outline steps to assess cultural competence in a healthcare organization.

KEY TERMS

Cultural competence   Diversity management
Cultural diversity   Health disparities
Cultural synergy   Limited English proficiency
Culture   Minorities

INTRODUCTION

The cultural profile and complexion of the U.S. population is changing. Migration and high birth rates among non-white groups are redefining the American racial and ethnic mix. **Table 3.1** displays projections from

the 2010 Census indicate that by 2050, over half the U.S. population will be non-white (Vincent & Velkoff, 2010).

People from diverse racial and ethnic backgrounds will make up the majority of the U.S. population by 2050 (Passel & Cohn, 2008). This increased racial and ethnic diversity will result in a more diverse workforce than in years past. Leaders of healthcare organizations will need to embrace this diversity and implement strategies that ensure that different cultural beliefs and attitudes are respected and valued by all members of the organization. Additionally, healthcare leaders must ensure that today's employees are knowledgable and skilled in communicating with and working with colleagues and clients whose backgrounds, needs, and expectations are different from their own.

Healthcare leaders can promote employee and organizational competence in this arena through training initiatives that include assessment of learned skills and performance. Successful training begins with an understanding of the common terms that refer to diversity and cultural competence.

DIVERSITY, DIVERSITY MANAGEMENT, AND CULTURAL COMPETENCE: BASIC DEFINITIONS

The definition of diversity often depends on the context of a discussion. Diversity can encompass any characteristic used to differentiate one person from another (Hubbard, 2004, p. 33). For some, diversity broadly defines people in terms of age, education, lifestyle, sexual orientation, geographic origin, personality, and education (Thomas, 1990). Others view diversity as a more focused emphasis on race, ethnicity, religion, and gender (Dickie & Soldan, 2008). Diversity may refer to any perceived difference among people:

Table 3.1 Projected Proportions of U.S. Population by Race and Ethnicity

| Race/Ethnicity	2010		2050	
White	246,630	79.5%	324,800	74.0%
Black	39,909	12.9%	56,944	13.0%
Native American, Alaska Native	3188	1.0%	5462	1.2%
Asian	14,415	4.6%	34,399	7.8%
Native Hawaiian, Pacific Islander	592	0.2%	1222	0.3%
Two or more races	5499	1.8%	16,183	3.7%
Hispanic	49,726	16.0%	132,792	30.2%
Totals	**310,233**		**439,010**	

Source: Data from U.S. Census Bureau. (2008). National population projections: Released 2008. Retrieved November 29, 2012 from www.census.gov/population/projections.

age, functional specialty, profession, sexual orientation, geographic origin, lifestyle, position and tenure in an organization (Dobbs, 1996). **Cultural diversity** refers to attitudes, values, and behaviors that may be shared by a group of people or by an organization.

A model helpful in comprehending the dimensions of diversity displays four concentric circles, each listing factors that affect an individual's attitudes and behaviors and his or her ability to work with colleagues and to effectively provide products or services to clients (see **Figure 3.1**).

At the center of the diagram, in the inner circle, is Personality, one's unique self and style. The next circle includes intrinsic factors such as age, race, gender, ethnicity, and sexual orientation. The third circle adds external factors such as geographic location, income, religion education, and work experience. The last circle cites organizational influences such as position classification, division or department, seniority, management status, and union affiliation (Gardenswartz & Rowe, 1998). This model helps identify major factors that affect employees' behaviors and attitudes and thus influence their ability to work with others. These dimensions can be used to understand similarities and differences among employees and thus promote knowledge about personal and cultural differences between workers and clients.

Managing diverse workers and clients requires respect and sensitivity to different cultural beliefs, practices, and values. **Cultural competence** means being able to understand the organizational factors that support or obstruct cultural sensitivity. It can be defined as the ability to successfully adapt to an unfamiliar cultural setting (Moua, 2010) and to use knowledge

Personality
Internal Factors
External Factors
Organizational Factors
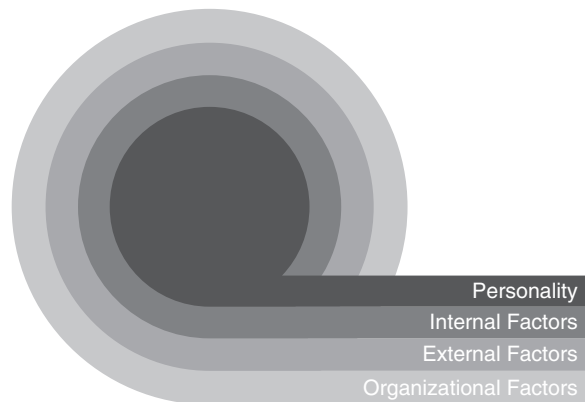
Figure 3.1 Diversity Model

about other cultures to reshape one's thinking and behavior to be more sensitive and responsive to cultural differences (Thomas & Inkson, 2009b).

Healthcare professionals practice cultural competence when they embrace and respect different cultural backgrounds, beliefs, and values, and take cultural diversity into account when providing healthcare delivery (Betancourt, 2006, p. 3). Since 2000, attention has focused on ways to address health disparities among minority populations. Cultural competence is one way to address health disparities and to promote equity in the delivery of health services. Generally, cultural competence refers to the ability and willingness to respond respectfully and effectively to people of all ethnic, cultural, and religious backgrounds (McDaniel, 2000). Cultural competence, especially at the organizational level, can be learned and developed and thus provides a significant way for management to reduce disparities among diverse patients. The following definitions help to distinguish between disparities in health status with disparities in the delivery of health services. Healthcare disparities are amenable to culturally competent management practices, and they in turn can influence health disparities.

Health disparities are health differences in individuals' or the public's (population) health that can be ascribed to social, economic, or environmental factors (National Partnership for Action, 2011). Race and ethnicity are commonly used to analyze U.S. health disparities.

Healthcare disparities are also differences in the amount and quality of health care that various groups are able to access or to receive. Racial and ethnic **minorities**, for example, comprise almost a third of the U.S. population but account for more than half of the uninsured. As a result, their access to primary care and other health services is limited (National Association of Community Health Centers, 2011). Furthermore, there is increasing evidence from the Institute of Medicine and other health policy studies that suggest underrepresented minority patients have less access to quality care and thus have poorer outcomes than nondiverse patients (Collins et al., 2002). Reports also highlight minority patient distrust that is due to perceived discrimination by providers and healthcare institutions. Shortages of culturally competent healthcare providers have had a negative impact on ethnic populations, especially for those with limited English proficiency (IOM, 2002b).

Cultural Competence in Health Care

Cultural competence in health care emerged in the 1990s as diversity in the United States continued to grow. In 1999, the Institute of Medicine (IOM) published the report "To Err Is Human," which discussed medical errors

such as medication and surgical blunders that resulted in some 44,000 deaths each year (Kohn, Corrigan, & Donaldson, 2000). In 2001, the IOM released "Crossing the Quality Chasm," identifying major gaps between expected quality of care and measured quality of care, most significantly for people of color. The IOM followed with another report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" in 2002 , which identified a set of root causes leading to these racial disparities (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Smedley, Stith, & Nelson, 2003). The identified root causes included:

- *Health system factors*. These highlight the difficulty minority patients have in accessing and navigating the complexities of the healthcare system, especially when language barriers exist.
- *Care process factors*. These causes include provider communication problems such as lack of knowledge and skills, prejudice, and discrimination, which contribute to patient mistrust.
- *Patient level factors*. These factors include patients' refusal of services, noncompliance or poor adherence to treatment, and delay in seeking needed care.

Cultural competence was initially viewed as a way to eliminate cultural and language barriers between providers and patients with **limited English proficiency** (LEP). By 2005, efforts to enhance cross-cultural health delivery had broadened beyond the acknowledgment and addressing of language differences to include an understanding of how patients from different cultures viewed health and illness. Researchers studied various cultural traditions and perspectives to develop tools for enhancing communication in clinical encounters between healthcare providers and their patients. To improve health outcomes as well as to bolster client satisfaction, healthcare organizations instituted training programs for their employees that built knowledge and skills in this arena. These programs typically included discussions of the impact of race and ethnicity on health care, the value of trust in patient–provider relationships, the role of social support systems, and the benefits of health literacy. Training helped employees to explore their own attitudes and biases, and develop tools to better communicate with colleagues and clients from different backgrounds. Providers were guided to "walk in their patients' shoes" and to view healthcare delivery "through their patients' eyes" (Beach, Saha, & Cooper, 2006).

By 2009, the Joint Commission, as part of a larger initiative to increase healthcare quality and safety through effective communication and cultural competence, approved new requirements to improve patient–provider communication for hospitals (Wilson-Stronks &

Tschurtz, 2010). New Joint Commission Standards of Practice were established in 2010 to promote culturally competent inpatient care and foster quality outcomes for diverse patients. These standards provided an additional rationale for healthcare leaders to build and evaluate cultural competence at all levels of their organizations, from the governing board to the frontline staff.

Culturally competent systems are designed to value diversity, to instill the capacity for cultural self-assessment and adaptation to diversity, and to promote knowledge about various cultures within and across institutions (Saha, Freeman, Toure, Tippens, & Weeks, 2008). Healthcare leaders responsible for cultural competence at system levels may incorporate the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). There are 14 standards on culturally and linguistically appropriate services (Office of Minority Health, 2001). The 14 CLAS standards include four federal requirements or mandates, nine recommended mandates or guidelines, and one voluntary adoption or recommendation, all surrounded by three themes: (1) Culturally Competent Care, (2) Language Access to Services, and (3) Organizational Supports. The CLAS standards recommend the employment of healthcare providers and staff that are ethnically similar to the patient community served and to collect and track data on quality of care for each demographic population. In 2011, the Department of Health and Human Services upgraded the CLAS standards. Revisions included professional interpreters as essential team members in the healthcare workforce and the establishment of an online national registry of certified interpreters for healthcare facilities (Koh, Graham, & Glied, 2011).

A Competitive Advantage

Corporations such as IBM have made **diversity management** a successful strategy in reaching out to diverse customers. Under Lou Gerstner's leadership, IBM "made differences matter," as the company developed products that would capture the attention and interest of this growing market (Thomas, 2004). Recent population growth and future demographic projections indicate that consumers of health care will also continue to increase in diversity. As patients become more informed and active in choosing providers and health services, healthcare organizations will be increasingly competing for consumers based on the perceived quality of customer service. Delivering services that meet the different cultural needs

and preferences of diverse consumers will help a healthcare organization gain a competitive advantage.

Healthcare leaders can unfortunately face challenges when they begin implementing diversity management strategies. For example, attempts to increase diversity in a few organizations have not been successful because of employee resistance, with resulting impaired organizational performance due to heightened tension and conflicts among workers (Thomas, 2004; Thomas & Ely, 1996).

Leaders can shape the climate and **culture** of their organizations by building the capacities (i.e., the knowledge and skills) of their employees (Schein, 2006). Today's healthcare leaders need to create an environment in which diversity and culture flourish, and conflicting values can be expressed, examined, and mediated through education and dialogue (Moua, 2010). Healthcare leaders play a critical role by modeling cultural competence, by visibly and publicly supporting the value of diversity, and by providing opportunities for employees to engage in active learning that promotes acceptance of "differences." Successful leaders serve as key role models who are culturally sensitive and competent organizational representatives. In short, leaders must learn to "walk the talk" before expecting others to do so.

Leading Organizations Toward Cultural Competence

Although senior management may be less involved in the day-to-day operations that require use of cultural competence skills, their support and guidance are essential to the development of an organizational culture and climate that promotes and supports diversity and cultural competence. Leaders are critical for the successful implementation of cultural competence because they:

- Develop the mission, vision, goals, and objectives for the organization
- Set the "tone" of the organization and nurture organizational ethics and values
- Have the "big picture" of the organization in their sights
- Coordinate strategic planning efforts and initiatives, and engage in assessment of initiative effectiveness
- Have the authority to commit resources
- Deal with a broader range of constituencies

Senior management must commit to and be accountable for actions that promote individual and organizational cultural competence. Without

leadership support, cultural competence efforts may flounder or fail. Dreachlin and Hobby (2008) suggest that leaders can promote cultural competence by:

1. Ensuring that their organization recruits and retains a culturally diverse workforce
2. Including culturally appropriate patient services in the organization's strategic goals
3. Routinely assessing achievement of these goals during the strategic planning and quality improvement processes
4. Assigning responsibility for promoting the organization's cultural diversity goals to a dedicated person, office, or committee
5. Annually reporting to constituents about the organization's performance in meeting the cultural and language needs of the service area

Successful promotion of organizational cultural competence is enhanced when:

- *Leaders make diversity a priority*. Leaders of healthcare organizations are tasked with identifying and implementing organizational priorities. Leaders promoting cultural competence elevate diversity to priority status and see it as a critical factor for innovation (Moua, 2010). This priority can be expressed via a statement of mission and/or vision that includes a commitment to providing culturally competent services. Leaders can advocate for the benefits of diversity with administrative and clinical employees, governing boards, and community partners.
- *Leaders get to know people and their differences*. Culturally competent healthcare leaders remain visible and engaged with organizational staff and clients, practicing and modeling cultural competence skills that can then be adopted by employees serving patients. Additionally, leaders who regularly meet and interact with employees gather cultural information that can help foster improved communications, relationships, and trust among diverse individuals and groups within the organization. Leaders who acknowledge that they are open to learning more about a culture can enrich communication by inviting intercultural dialogue with employees (Moua, 2010). Such dialogue can foster employee willingness to ask for help and to provide input.
- *Leaders create cultural synergy*. **Cultural synergy** means that we can learn from others and others can learn from us. This synergy occurs when diverse individuals work together to solve problems. Leaders

willing to create cultural synergy must draw on the diverse resources of the organization to contribute to problem solving (Adler, 2002). Cultural synergy can be facilitated by:

· *Addressing a situation or problem from the points-of-view of multiple cultures.* Different cultures may view issues and challenges from different perspectives. Soliciting the perspectives of others promotes greater understanding among participants in a problem-solving group and allows leaders and teams to get a more complete picture of relevant concerns and possible solutions.

· *Interpreting issues and concerns from a cultural perspective.* An individual may perceive his or her behavior as rational, but people from different cultures may misinterpret or misunderstand the behavior. Considering cultural factors in the interpretation of behavior can promote a more positive perception of the behavior and can identify common ground in thoughts, feelings, and actions among persons from different cultures. These help to develop new culturally-creative solutions.

Standards help workers hold themselves to high levels of performance. Standards do not necessarily prevent intercultural conflicts, but they can promote culturally competent and appropriate behavior. Clearly defining expectations for culturally competent professional behavior sets the stage for employee accountability. When employees are held accountable for culturally competent behaviors in an intercultural work environment, organizations report higher levels of respect and trust (Moua, 2010). Culturally competent behaviors can be assessed among colleagues, as well as between staff and patients. Assessing whether patients' cultural preferences are addressed in the delivery of health care should be a critical part of a healthcare organization's quality improvement program. Leaders are responsible for ensuring evaluation of these parameters to ensure that quality care is delivered in culturally appropriate ways to diverse patients.

To help leaders promote diversity and cultural competence, key steps and processes are listed in **Table 3.2**.

CREATING CULTURAL COMPETENCE IN HEALTHCARE ORGANIZATIONS: THE ROLE OF TRAINING

Thomas (2004) suggests that companies that have effectively managed diverse workers have created environments for active learning within the organization. One approach to creating and maintaining these learning environments is to provide dedicated employee training in cultural

Table 3.2 Leaders' Tool Kit

Steps	Process
Define diversity	Review definitions of diversity in healthcare organizations.
	Develop a workable definition of diversity and cultural competence that suits the needs of the organization.
Develop a business case for diversity and cultural competence	Identify organizational mission and strategic goals.
	Identify customer demographics and assess needs from a cultural perspective.
	Establish potential benefits of diversity management and cultural competence.
	Assess costs of poor or nonexistent diversity management.
	Identify areas of diversity management that the organization does well.
	Research diversity management among competitors and within market area.
	Identify strategies and opportunities for becoming an employer of choice.
	Develop a business case for diversity and cultural competence to share with stakeholders within and beyond the organization.
Sell diversity to senior management	Compile information to establish the business case for diversity management.
	Align the report with the strategic goals of the organization.
	Formally present the report to the CEO, executive team, and board of directors.
	Seek feedback on the submitted report.
Engage senior managers	Seek diversity champions in senior management as advocates.
	Form a diversity working group that includes the CEO to develop a diversity strategy with initiatives.
	Establish the commitment of senior leadership to mentor and support diversity programs.
	Enlist senior managers to serve as educators or mentors for employee training programs.
	Establish performance measures for senior leadership to monitor the effectiveness of the initiatives and to develop necessary revisions and refinements based on the periodic assessments.

Source: Courtesy of Janine O'Flynn, André Sammartino, Karen Lau, Aurora Ricciotti, & Stephen Nicholas. (2001). ATTRACT, RETAIN AND MOTIVATE: A TOOLKIT FOR DIVERSITY MANAGEMENT, Department of Immigration and Multicultural and Indigenous Affairs in Cooperation with the Australian Centre for International Business.

competence. Training objectives include the development of self-awareness and insight about personal assumptions and prejudices, of understanding of people's diverse expectations and behaviors, and of acceptance of differences.

Key training activities can help employees:

· Consider issues from a variety of perspectives
· Challenge their own assumptions and recognize the views of others as valid
· Reflect on and think about issues with an open mind and receptiveness to change
· Realize a higher awareness of our common humanity and their role as service providers

Training also requires assessment to document achievement of learning outcomes. Evaluations should be performed systematically and should assess pretraining and posttraining learning and performance. There are many different types of assessments that training programs can use, such as pre- and postsession surveys with self-reporting by attendees and participants, interviews with open-ended questions, and observations of behavioral change over time. In addition to supervisor and mentor reports, patient satisfaction surveys can contain items that allow evaluation of cultural competence performance for trainees who are delivering patient care. Assessments should also provide the opportunity for participants to suggest improvements for the training. Assessment data should be reviewed and utilized on an ongoing basis to modify and improve future training.

Individual and Group Cultural Competence Training

All diversity training programs need to have clearly stated goals and learning outcomes that will allow managers to evaluate their effectiveness. Managers and training specialists should have a clear idea of their intended objectives before launching their program. Once they know their "destination" or their goals, they can then design the educational activities needed to guide employees along the journey of change as well as the assessments needed to demonstrate employee achievements.

The process will begin with identified goals/objectives. Training will first strive to raise employee awareness about the identified issues, then move on to providing employees with the knowledge and skills to understand new perspectives, develop new attitudes, and change professional behaviors. Finally, comprehensive assessment tools will measure the extent to which employee knowledge, attitudes, and behaviors have been enhanced. Clements and Jones (2002) developed a list of measures to help assess learning goals for cultural competence training programs (see **Table 3.3**).

Table 3.4 presents an instrument that can be used to assess individual attitudes and behaviors related to cultural competence and can spur the self-examination helpful in changing professional behaviors.

Table 3.3 Learning Goals for Cultural eLearning Goal

Goals	Assessment Process
Increased knowledge	Self-report, tests, interview, group discussion
Behavior change	Role-play, group discussion; work assessment, self-report
Attitudinal change	Self-report, questionnaire, workplace assessment, group discussion

Table 3.4 Cultural Competence Instrument

Question	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I try to consider the other person's point of view before giving my opinion	☐	☐	☐	☐	☐
Most of the time I am aware of my feelings	☐	☐	☐	☐	☐
I can usually explain to others how I am feeling	☐	☐	☐	☐	☐
I am tolerant when someone is argumentative	☐	☐	☐	☐	☐
I don't usually find it difficult to talk to people who do not share my views	☐	☐	☐	☐	☐
I am generally conscious of what others are feeling	☐	☐	☐	☐	☐

To help individuals manage their personal growth and relationships with others, Hemphill and Haynes (1997) developed an assessment that rates perceptions and patterns of experiencing and displaying emotions. **Table 3.5** can be used to help individuals assess their work relationships.

After filling out the self-reports, training participants can be guided in exploring their self-knowledge, beliefs, values, attitudes, and communication styles, and can learn new skills to improve professional relationships with colleagues and clients through, for example, group discussions and role-play.

After the completion of training or, in many cases, on an ongoing basis, employees should participate in assessments that can identify areas in which additional training would be helpful, as well as periodic training refreshers to promote continued active learning.

Table 3.5 Workplace Relationship Skills

Limiting Level	Me	Mastery Level
Judgmental	1 2 3 4 5	Nonjudgmental
Closed minded	1 2 3 4 5	Transformational
Insensitive	1 2 3 4 5	Empathic listener
Fear of change	1 2 3 4 5	Open to change
Discriminating	1 2 3 4 5	Open to differences
Stereotyping	1 2 3 4 5	Open minded

Organizational Cultural Competence

Both organizations and individuals are tasked with being culturally competent. Assessing the cultural competence of organizations was addressed by the Health Resources and Services Administration (HRSA) in 2002, which developed the Organizational Cultural Competence Assessment Profile to assess whether services are delivered in a culturally competent way by organizations.

This organizational assessment profile has three major parts: domains of cultural competence, focus areas within each of the domains, and indicators associated with each of the focus areas.

Within the domains of cultural competence are six areas of organizational functioning to assess:

1. Organizational Values
2. Governance
3. Planning and Monitoring/Evaluation, Communication
4. Staff Development
5. Organizational Infrastructure
6. Services/Interventions

Within each domain, key focus areas are specified along with indicators for assessment. An example can be found in the focus area of "culturally competent oral communication," as related to the new Joint Commission standards for hospital interpreters (Wilson-Stronks & Tschurtz, 2010). The indicators in **Table 3.6** can be utilized in assessment, along with potential query areas.

Once a set of indicators has been selected and the survey instrument developed, the next step is to gather information from all levels of the organization. As noted earlier, evaluative data from training obtained from surveys and interviews are common tools for collecting quantitative and

Table 3.6 Culturally Competent Oral Communication

Structure Indicators	Process Indicators	Outcome Indicators
Provide access to trained interpreters	Provide training of interpreters	· Number of languages available at point of first contact and at all levels of interaction. *Numerical data to be benchmarked with other similar organizations.*
Is there adequate access to trained interpreters?	*Is interpreter training provided by the institution?*	· Use and timeliness of interpretation services. *Numerical data to be benchmarked with other similar organizations.*
	What learning outcomes have been developed?	· Client/patient understanding of interpreted material. *Interviews or self-report surveys in the client's language.*
	How effective is this training based on assessments?	· Low interpretation errors. *Numerical data to be benchmarked with other similar organizations.*

qualitative data related to an organization's cultural competence. These measures and indicators of cultural competence can contribute to an internal scoreboard to help monitor the effectiveness of an organization's diversity and cultural competence initiatives, as well as compare against the data from other institutions via benchmarking programs.

Leaders need to select a set of indicators that reflect the organization's mission, goals, and priorities regarding diversity and cultural competence, and develop assessments to measure progress in these areas. Indicators should also be analyzed by representatives of the various ethnic and racial groups served by the organization to help ensure that cultural competence initiatives being assessed are successfully targeting access and quality of care for their constituency. Tracking such indicators can help an organization monitor the extent to which its cultural competence initiatives are reducing disparities in health care and health status among their clientele. Findings from assessments should be reported routinely and periodically to the organization's governing board and key stakeholders. These actions demonstrate the organization's commitment and accountability to diversity and cultural competence.

Challenges and Recommendations

The culturally competent leader understands that organizational buy-in is imperative to launching and maintaining successful cultural competence initiatives. Maintaining cultural competence as a focus and priority is critical to implementation success. **Table 3.7** lists some of the key implementation challenges for healthcare leaders with regard to cultural competence.

Table 3.7 List of Challenges for Cultural Competence Implementation

Lack of organizational commitment to equity, diversity, access, and excellence	Lack of education/training about the cultures served
Absence of human resource practices and policies related to the inclusion and incorporation of racial and ethnic minority groups	Failing to recruit/retain and match the demographic of the employees with the community served
Lack of organizational resources to support diversity recruitment and retention	Failing to institute linguistic policies that conform to Culturally and Linguistically Appropriate Services (CLAS) standards for LEP patients

Healthcare leaders should be aware of these challenges and be proactive and systematic in evaluating and promoting diversity-friendly personal as well as interpersonal and organizational practices and policies. Cultural competence remains an integral value for healthcare organizations that should be integrated into the organizational mission, vision, and goals, strategic planning, day-to-day operations, and quality assessment and improvement programs.

There is a clear and direct link between healthcare organizations' cultural competence and the quality of care provided to consumers and employees. The need for cultural competence and diversity management to help an organization achieve competitive advantage is clear. According to Dansky and colleagues (2003), "If an organizational workforce creates value, it is hard to imitate, and is rare, it will contribute to sustained competitive advantage. An organization meets these criteria with a culturally diverse workforce that performs in a supportive, enabling milieu" (p. 245).

The research evidence supporting the positive effects of cultural competence on organizational performance is slowly emerging. Today's healthcare leaders are charged with developing, implementing, and assessing cultural competence throughout their healthcare organizations. Health outcomes data that have been analyzed by ethnicity and race are important accountability measures to determine whether cultural competence activities and training are making a difference in access to care and patient safety. Diversity includes many aspects of human behavior and attributes, thus necessitating broad definitions that extent beyond race and ethnicity. By collecting and studying healthcare outcomes via diversity parameters, healthcare organizations will be able to develop evidence-based cultural competence practices that promote patient access and reduce healthcare disparities.

Healthcare leaders are being exhorted by federal regulatory agencies such as the Department of Health and Human Services and accreditation bodies

such as The Joint Commission to make cultural competence an organizational strategic initiative that can help address disparities in access and quality of care for underrepresented ethnic and racial groups. If healthcare leaders accept and embrace this challenge and strive to develop culturally competent employees and organizations, they will, in turn, contribute to the equity and safety of the U.S. healthcare delivery system for our increasingly diverse population.

SUMMARY

Faced with an increasingly diverse workforce and patients, healthcare leaders are challenged to develop organizational cultures that effectively embrace, respect, and serve those from different cultures and backgrounds. This chapter provides a description of several seminal external forces (e.g., Institute of Medicine reports and census data) that identified disparities in the quality and safety of health services. This is coupled with growing evidence that supports the influence of organizational cultural competence in the delivery and management of quality health care. A practical set of tools is provided to plan and evaluate cultural competence training across all levels in an organization and thereby helps leaders create a culture committed to diversity and cultural competence.

Discussion Questions

1. How can leaders influence change regarding diversity in their organizations?

2. Explain the role of cultural competence training and education.

3. An important part of cultural competence and diversity management is assessment. Discuss a few key ways to assess knowledge, attitudes, and behaviors.

4. Discuss how a health leader can monitor the success of cultural competence activities.

Case Study: Cultural Competence

An African American woman enters a healthcare facility where she is to receive a magnetic resonance image (MRI) of her spine. She has long hair in the style known as "locks." She is greeted by the receptionist and asked

to have a seat in the waiting area until the technician is ready to see her. A white, male technician arrives to escort the woman in for her procedure and briefly discuss the process of MRI with her. During his overview, he indicates that she will have to remove any metal objects (such as pins in her hair or jewelry) and that she should remove her hair for the process. The woman is appalled by his latter statement and indicates to him that her hair is her own and cannot be removed. He responds by stating that he has served a number of black women who have weaves and other "false" hair often held in by pins, so he was basically taking a precaution. The woman is highly insulted and asks to speak to the administrator on duty. A white woman, in an elegantly tapered suit, arrives, hears the concern, and explains to the African American woman that the technician meant no harm, but that it is the policy of the facility to be thorough with all patients in terms of the provision of information and that he was correct in inquiring about her hair in the manner that he did to ensure safety during the MRI process. She offers no apology and curtly responds, "I hope this resolves your concerns, as he was merely following our required protocol." The African American woman responds with a disappointed and curt thank you and leaves the building promptly, vowing never to return. She seeks her MRI at another facility.

Case Study Discussion Questions

1. What went wrong in this encounter?
2. Why was the patient offended?
3. What could be done to help patients better understand protocols in the future?
4. What role did culture play in this instance?
5. What training should be offered to the facility's employees?

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