

10-12-2012

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Citation

Golembeski, Susan and Ojeda, Maria M., "Measuring Cultural Competence in the Acute Care Setting" (2012). *All Publications*. 650.
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Measuring Cultural Competence in the Acute Care Setting

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Introduction

- Cultural competence (CC) is an important topic for today's health care organizations (HCO) (The Joint Commission, 2010; IOM, 2001; DHHS, 2001). Measuring & reporting CC within HCO has been identified as evidence of workforce training to increase organizational capacity to respond appropriately to the needs of diverse patient populations (National Quality Forum, 2009).
- South Miami Hospital (SMH) serves a diverse community. In 2000 the racial/ ethnic composition of the South Miami area was 38.9% non-Hispanic White, 24.1% African American, 34.4% Hispanic (any race), and 2.6% identified themselves as "other" (South Florida Planning Council, 2011).
- At SMH, a "Cultural Connection Team" (CCT) was formed to assure attention to issues regarding CC and CC-related training & education of staff. In 2003 the CCT identified a need to assess the CC of SMH staff.
- Few scientifically tested instruments were available to measure CC and 67% of instruments share concerns regarding their reliability & validity (Gozu, Beach, Price, Gary, Robinson et al., 2007).
- The "Promoting Cultural and Linguistic Competency Self Assessment Checklist" (CLCSAC) from the *National Center for Cultural & Linguistic Competence* was chosen to assess practices, beliefs, attitudes & values regarding cultural and linguistic competence (Goode & Bronheim, 2006). The CLCSAC is based upon a conceptual framework for CC that consists of three subscales, is scored on a 5-point scale, and higher scores indicate lower levels of demonstrated values & practices that promote CC (Goode & Bronheim, 2006).



Purpose

- The CLCSAC had not been standardized, and neither reliability nor validity had been established. The purpose of this analysis was to describe the psychometric properties of the CLCSAC resulting from this administration.

Methods

- The study gained Institutional Review Board approval in 2003.
- The design was cross-sectional and descriptive. A convenience sample of all staff members at SMH was drawn on two occasions, over a 6-year period.
- The CLCSAC was delivered in paper & pencil format and transferred to an electronic database for the purpose of analysis using IBM SPSS software V.19.
- The CLCSAC is based upon a conceptual framework for CC that consists of three subscales, is scored on a 5-point scale, and higher scores indicate lower levels of demonstrated values & practices that promote CC (Goode & Bronheim, 2006).
- For data reduction and increased relevancy to the acute care setting, a subset of 15-items representing the "Communication" and "Values & Attitudes" subscales were included in the study (Figure 1).
- Psychometric analysis was conducted in-aggregate by pooling responses from the two data collection periods. Demographic data was collected in addition to CLCSAC scores.
- Cronbach's alpha was calculated to determine internal consistency, confirmatory factor analysis was performed to evaluate construct validity.

| Communication Subscale | | |
|--|--|--|
| When interacting with individuals and families who have limited English proficiency... | | |
| 1. | I always keep in mind: limitations in English proficiency is in no way a reflection of their intellectual functioning. | |
| 2. | I always keep in mind: their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their own language of origin. | |
| 3. | I always keep in mind: they may or may not be literate in their language of origin or English. | |
| 4. | I use bilingual-bi-cultural staff skilled in the provision of medical interpretation during interventions for individuals and families who need or prefer this level of assistance. | |
| 5. | For individuals and families who speak languages other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them. | |
| 6. | I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own. | |
| 7. (Composite score – Items # 1, 2,3). | | |
| Values & Attitudes Subscale | | |
| 8. | I intervene in an appropriate manner when I observe other staff within my hospital engaging in behaviors which show cultural insensitivity, racial biases and/or prejudice. | |
| 9. | I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g., high value placed on the decision of elders, role of children). | |
| 10. | I understand that age and life cycle factors must be considered in interactions with individuals and families. | |
| 11. | Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives. | |
| 12. | I accept that religion and other beliefs may influence how individual families respond to illnesses, disease, and death. | |
| 13. | I understand that grief and bereavement are influenced by culture. | |
| 14. | I seek information from individuals that will assist in meeting the needs and preferences of culturally and ethnically diverse groups served by my hospital. | |
| 15. | I seek out professional development and training to enhance my knowledge and skills in the provision of care for culturally diverse groups. | |

Figure 1.

Results

Demographics

- A total of N=753 instruments were returned, N=743 completed the CLCSAC with a 2.5% rate of missing data. Seventy-six percent of the sample was female and 24% were males. Approximately 50% of respondents self-described as Hispanic, 17% Caucasian, 10% Caribbean/ "West Indies", 8% African American, 6% were Asian, and 9% "Other" (N=443).

Psychometrics

- All items in the scale were correlated with other items. The average inter-item correlation coefficient $r = .446$.
- Cronbach's alpha for internal consistency ($n=15$) was $\alpha = .904$ for the overall scale. The subscales also exhibited acceptable internal consistency with Communication ($n=6$) $\alpha = .846$, and Values & Attitudes ($n=9$) $\alpha = .855$. The split-half correlation was $= .710$.
- Confirmatory factor analysis & principal component analysis (PCA) with Varimax rotation was performed. Two factors with Eigen values ≥ 1.0 were extracted, accounting for 56.5% of the variance in the CLCSAC. PCA extracted 3 components with Eigen values ≥ 1.0 , accounting for 64.4% of the variance in the CLCSAC scores (Figure 2).
- Extracted factors did not match the composition of the Communication and Values & Attitudes subscales as originally described (Figure 1). Based upon the results of the PCA, the researchers determined the extracted components to represent: Avoidance of Labeling, Acceptance of Differences, and Actions demonstrating CC (Figure 3).

| Total Variance Explained | | | | | | | |
|--------------------------|----------------------|--------|--------|-------------------------------------|--------|-----------------------------------|--------|
| | Initial Eigen values | | | Extraction Sums of Squared Loadings | | Rotation Sums of Squared Loadings | |
| | Total | % Var | Cum % | Total | % Var | Total | % Var |
| 1 | 6.861 | 45.741 | 45.741 | 6.861 | 45.741 | 3.492 | 23.280 |
| 2 | 1.619 | 10.791 | 56.531 | 1.619 | 10.791 | 3.411 | 22.741 |
| 3 | 1.180 | 7.866 | 64.397 | 1.180 | 7.866 | 2.756 | 18.376 |

Extraction Method: Principal Component Analysis.

Figure 2.

| The "Promoting Cultural and Linguistic Competency Self Assessment Checklist" Rotated Component Matrix ^a | Component | | |
|--|-----------|------|------|
| | 1 | 2 | 3 |
| Avoidance of Labeling | | | |
| When interacting with individuals and families who have limited English proficiency... | .931 | .284 | .200 |
| 7. (Composite of items 1, 2, 3). 1. I always keep in mind: limitations in English proficiency are in no way a reflection of their intellectual functioning. | .764 | .366 | .189 |
| 2. I always keep in mind: their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their own language of origin | .845 | .290 | .095 |
| 3. I always keep in mind: they may or may not be literate in their language of origin or English | .816 | .111 | .230 |
| 6. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own. | .466 | .412 | .272 |
| Acceptance of Differences | | | |
| 9. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g., high value placed on the decision of elders, role of children). | .191 | .786 | .210 |
| 10. I understand that age and life cycle factors must be considered in interactions with individuals and families. | .159 | .791 | .273 |
| 11. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives. | .235 | .718 | .237 |
| 12. I accept that religion and other beliefs may influence how individual families respond to illnesses, disease, and death. | .292 | .708 | .261 |
| 13. I understand that grief and bereavement are influenced by culture. | .287 | .633 | .127 |
| Actions Demonstrating CC | | | |
| 4. I use bilingual-bi-cultural staff skilled in the provision of medical interpretation during interventions for individuals and families who need or prefer this level of assistance. | .227 | .112 | .649 |
| 5. For individuals and families who speak languages other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them. | .256 | .305 | .587 |
| 8. I intervene in an appropriate manner when I observe other staff within my hospital engaging in behaviors which show cultural insensitivity, racial biases and/or prejudice. | .167 | .283 | .558 |
| 14. I seek information from individuals that will assist in meeting the needs and preferences of culturally and ethnically diverse groups served by my hospital. | .056 | .263 | .763 |
| 15. I seek out professional development and training to enhance my knowledge and skills in the provision of care for culturally diverse groups. | .099 | .116 | .791 |

a. Varimax Rotation converged in 5 iterations.

Figure 3.

Conclusions

- Acceptable internal consistency and split-half reliability was observed for the CLCSAC. Factor analysis did not support construct validity of the 2-subscale structure. The researchers determined the extracted factors to represent: Avoidance of Labeling, Acceptance of Differences, and Actions demonstrating CC.
- Like other CC assessment instruments, the psychometric properties exhibited by the CLCSAC in this analysis will require replication in acute care environments with varying levels of diversity among staff (Gozu, et al., 2007).

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