Chapter 1

Introduction

Overall, the purpose of this text is to explore in depth, at an introductory level, a good, solid rationale for healthcare administrators, public health practitioners, and students in the professions of health services administration and public health to consider the development of robust cultural competence plans as a necessity for enhancing the provision of quality care and as a business imperative. In this text, it is recommended that healthcare organizations and public health entities develop a cultural competence plan, akin to a business plan, recognizing the different needs and perspectives of the internal and external communities served. The result will be coordinated processes and policies that facilitate improved outcomes, improved patient satisfaction, mitigation of malpractice, and increased market share leading to an increase in the fiscal bottom line of healthcare and public health organizations.

It appears that the United States is going to embark on some type of healthcare reform. What it will ultimately consist of is unclear at this time. The current administration, under the leadership of President Barack Obama, is wrestling with this monumental task while the nation is watching the process unfold. The reform process has led to a national debate that is warranted. One significant consideration that needs to be included as part of the various aspects of healthcare reform is cultural competence. Although cultural competence is one of the initiatives of the US Department of Health and Human Services (DHHS) Office of Minority Health (OMH), as will be discussed in this text, it should become an intricate aspect of health service administration and public health as part of the fabric of every organization. Just as electronic medical records (EMRs) are needed to ensure that medical errors are reduced, cultural competence initiatives are needed to reduce malpractice claims and enhance customer service, as well as address other ongoing concerns. This book serves as a mere starting

point for students, health service administrations, and public health practitioners to consider cultural competence as an imperative, but hopefully, cultural competence will become a significant component of the healthcare reform agenda.

American society appears ready for change and cultural competence. Recently, Congress formally apologized for the enslavement of African American people in the United States. Furthermore, for the first time in American history, the nation has an African American serving as President of the United States and an Hispanic woman serving as a Supreme Court Justice. Additional firsts for this nation include an African American Attorney General and an Asian American Secretary of Energy. Diversification is taking place at high levels in the United States, but this alone is not sufficient. There are still serious issues pertaining to race, communication, and cultural understanding in the United States. A specific example occurred when a prominent African American professor, Dr. Henry Louis Gates, Jr., who is the director of the W.E.B. Dubois Institute for African and African American Research/Studies at Harvard University, was arrested in his home by a White police officer. Per the media, a report of a potential burglary of Dr. Gates's home was phoned in to the police department by a neighbor of Dr. Gates. There was no burglary, as Dr. Gates was the person attempting to get into his home with his driver after he returned home from a long journey from China where he was conducting research. The ensuing communication between Dr. Gates and the police officer, who arrived at Dr. Gates's home to investigate the alleged burglary, went awry after Dr. Gates allegedly showed two forms of identification and established that it was in fact his home, leading to the arrest of Dr. Gates. Subsequently, Dr. Gates accused the officer of racial profiling, and the officer accused him of disorderly conduct. The result has been a nationwide discussion of racial issues in the United States that has included a comment by the President of the United States from his vantage point as an African American person.

Furthermore, the recent incident which occurred in January 2010, when the book by *Atlantic Reporters* Mark Halperin and John Heilemann, entitled *Game Change* was released, involving comments made by the Senate Majority Leader, Harry Reid during the 2008 Presidential campaign, led to a firestorm of debate and discussion. As indicated in the *Game Change,* Harry Reid stated that President Obama would win over John McCain, because he is "light skinned" and has no "Negro dialect." This racially insensitive comment led to requests for Senator Reid to step down from his Senate leadership position, a statement from President Obama and intense debates within all forms of media. These particular occurrences are clear indications

that, specific discussion needs to continue to occur regarding the topics of race, culture, ethnicity, sensitivity, and diversity, among others.

The question that has surfaced since the election of the first African American President of the United States and African American First Lady of the United States is whether a postracial society has been accomplished. Former President Carter stated that he believes the current upheavals associated with healthcare reform in terms of rallies and town meetings, at which harsh signs have appeared depicting President Obama as a Nazi (Hitler) and other unsavory characters, are a result of racism toward President Obama because he is African American. During an interview on *NBC Nightly News* on September 15, 2009, with the television network anchor, Brian Williams, former President Carter stated the following:

> I think an overwhelming portion of the intensely demonstrated animosity toward President Barack Obama is based on the fact that he is a black man, that he's African American. I live in the South, and I've seen the South come a long way, and I've seen the rest of the country that share the South's attitude toward minority groups at that time, particularly African Americans. That racism inclination still exists. And I think it's bubbled up to the surface because of the belief among many white people, not just in the South but around the country, that African-Americans are not qualified to lead this great country. It's an abominable circumstance, and grieves me and concerns me very deeply.

Additionally, assassination threats toward President Obama are up 400%, according to several news establishments, including Cable News Network (CNN), and there has been an actual call for his death from a White minister. Although all are not in agreement with former President Carter's assessment, if he is accurate, then the United States has not achieved the goal of becoming a postracial society, and the need for ongoing dialogue about issues pertaining to race and culture becomes imperative.

This need for discussion and dialogue is relevant to health care and public health, because it is necessary to ensure that skill sets are in place, from a cultural vantage point, to deal with the rapid demographic changes and to close the long-standing health disparity between minority groups and White people. Specifically, if full-fledged cultural competence efforts are realized in the context of healthcare reform efforts, patients/clients/customers, many of whom are minorities, will be better served, which will lead to improved quality of care. Cultural competence is imperative and in our nation's best interest in terms of the provision of efficacious health care and public health.

The key questions pertaining to this text are as follows: What is cultural competence, and why is it relevant to health care, particularly in terms of health services administration and public health? Although the United States has never been a homogeneous population, the makeup of the population is changing as a result of immigration patterns and increasing birthrates among racially, ethnically, culturally, and linguistically diverse groups. The number of people who speak languages at home other than English has also increased dramatically. The foreign-born population in the United States has increased substantially, with the most rapid growth among Hispanics, which is now the largest minority group. African Americans/Blacks, formerly the largest minority group, are now a close second. Hispanics are an ethnic group, based on the language spoken (Spanish), but the primary language spoken is what distinguishes Hispanics from mainstream America. Therefore, the data associated with the increase in the number of Hispanics in the United States, and the number of Blacks and Whites (and other groups), are confounded because of the fact that Hispanics may be White or Black (or other) in terms of race. Consequently, perhaps their increasing numbers should be allocated in terms of race, not ethnicity, because this is how other groups are categorized in the United States. For example, Haitians speak Creole but are generally identified and categorized as Black in terms of race and not as a distinct group based on the language they speak. Granted, their numbers are much smaller, but it is not their language that is used to identify them in the United States, but their race, which is further delineated by their nationality (Haitian).

Nevertheless, the trend of an increasing number of minorities in the United States is expected to continue, which is leading to the use of the term *emerging majority*. The emerging majority includes all groups of minorities as established by the Office of Management and Budget (OMB) of the US government. OMB establishes the racial and ethnic categories in the United States, which, in terms of minorities, are African Americans/Blacks (race), Hispanics (ethnicity), Asian/Pacific Islanders (race), and Native Americans and Alaska Natives (race). Therefore, it is imperative that the provision of health care take place in a culturally competent manner in an effort to meet the needs of the emerging majority (ever increasing collective of minority groups) in the United States.

Additionally, there have been numerous approaches and attempts to define cultural competence. Linguistic competence has also been defined, which is equally important in ensuring optimal health care. Early in this text, a clear and cogent definition of this term will be provided, as offered by the OMH of DHHS, that takes both cultural and linguistic competence into consideration. OMH has also developed a significant initiative to address

these concerns, and thus, an overview explaining why healthcare organizations must function in the context of respect and responsiveness to the cultural diversity of communities and patients/clients/customers served is also provided in this text. The effort to establish the necessity for cultural and linguistic competence and diversity was initiated in December of 2000 when the OMH released the Culturally and Linguistically Appropriate Services (CLAS) standards in health care. There are a total of 14 standards comprising mandates, guidelines, and recommendations. These standards are delineated and reviewed in this text. Furthermore, a clear distinction is made between the terms cultural competence and diversity. Often, the notion of ensuring cultural competence within healthcare administration and public health is considered to be the same as diversifying healthcare organizations, which is clearly inaccurate, although the need for diversity is explored and established as necessary to the same degree as cultural and linguistic competence. This concept of cultural and linguistic competence and diversity as three important and distinct necessities is clarified and thoroughly explained.

Furthermore, the role of healthcare administrators and public health officials is to plan and implement cultural competence within organizations in compliance with CLAS, state, federal, and accreditation requirements. Healthcare organizations increasingly rely on private accreditation entities, such as the Council on Education for Public Health (CEPH) and The Joint Commission, to set standards and monitor compliance within them. Cultural and linguistic competence is emerging as an important aspect of the accreditation process for healthcare organizations. Cultural competence is also relevant to healthcare organizations from a fiscal vantage point because it makes business sense. If healthcare patients/clients/customers are receiving care and services that are attentive to their cultural and linguistic needs and provided by a diverse staff that is reflective of those who are being served, they are more apt to use or return to a given facility and share their enthusiasm with others in their communities. In addition, malpractice claims will be reduced as result of enhanced cultural and linguistic communication.

There are a number of books that are currently available that address the topics of cultural competence, linguistic competence, cultural proficiency, diversity, and other related matters of concern. Some of these texts include descriptions and details about the various minority groups in the United States, their health concerns, and existing health disparities. What distinguishes this text from the others is the provision of details about minority groups that will enable service providers to appreciate, value, and understand specific insights about various cultures. For example, in Chapter 2,

there is discussion regarding the most appropriate term to use in regard to ethnic and racial groups in the United States. Is it best to use the term Black or African American or both? Is it most appropriate to use the term Native American or Indian when communicating with indigenous American people? Although these questions do not have definitive answers because of their complexity and individual preferences, insight is provided as to the origins of the terms, giving helpful information that will prove useful in decision making as to whether one should use one term over the other when communicating with patients/clients/customers. This is an important detail because it is part of the culture of people of African descent and indigenous Americans, and failure to understand and use the appropriate terminology may prove to be problematic when serving them.

Furthermore, this book endeavors to explore the aforementioned designation of the Hispanic population as an ethnic rather than a racial group by the OMB, as mentioned previously. When one encounters an Hispanic person in a healthcare or public health setting, it is pertinent to determine their race and nationality because the nation that a person who speaks Spanish comes from will determine his or her culture, not the fact that he or she speaks Spanish. As an example, in viewing the literature regarding the new Supreme Court Justice, Judge Sotomayer, the preponderance of literature referred to her as the first Hispanic nominee. Although this is true, what is her race? Is she White, Black, Asian, or Native American? Given that she is also from Puerto Rico (a US territory), how does she differ culturally from other Hispanics who are not from Puerto Rico but perhaps from the Dominican Republic, Guatemala, or Honduras? The term Latina was often used in discussions about her in the media. What is the difference between the terms Hispanic and Latino(a)?

Such inquiry matters in health care and public health because differences in culture based on nationality/lineage impact health-seeking behavior, diet, communication, and other relevant factors that are necessary to understand to provide optimal service. Often, data pertaining to Hispanics are strictly reported under the category of Hispanic without any detail regarding race or nationality. This is problematic because categorization of health data for Hispanics should include Black Hispanics under the Black/African American racial category and White Hispanics under White, and so forth, without exception, because Hispanics may be from any of the four racial groups determined by OMB.

Again, for each racial category, insight should also be provided regarding nationality because of the distinct cultural differences among the nations where people have their lineage. For example, a person from Nicaragua does not have the same cultural background as a person from the Dominican

Republic, although they both may speak Spanish, and a Black person from Jamaica has a very different cultural background from a Black person from Trinidad or from the United States. If dietary habits are considered, as an example, from a cultural perspective, there is significant variation, and hence, data regarding the various groups' health problems associated with dietary habits would have to reflect such differences. Thus, it is incorrect and culturally inappropriate to report data collectively on the health status of Black people, Asian people, Hispanic people, and Native American people without these considerations of nationality and cultural differences. Therefore, the intention of this book is to ensure that the reader understands the nuances of culture and what is necessary to know in ensuring culturally competent service. Ultimately, cultural competence is not only the right thing to do from an appropriate and altruistic vantage point but a business imperative, particularly with the significant, rapid, and continuous changes in the diversity of those served.

CHAPTER ORGANIZATION

This book contains 11 chapters, including this Introduction. There are learning objectives, key terms, conclusions, chapter summaries, chapter problems, references, and suggested readings within each chapter, beginning with Chapter 2. All key terms appear with definitions throughout the text and in the glossary at the end of the book. Also, at the end of the book are cultural competent attitudinal assessment surveys (for health services administrators, staff, and providers); a list of pertinent Web sites, journal articles, and books (from the past and present); a sample cultural competence plan; and an index for the reader's convenience.