Cultural Competency for Health Administration and Public Health

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Dedication

I lovingly dedicate this work to my husband, Jeffrey Rose, and our children, Courtney and Brandon Rose, whose presence has given my life deep meaning and purpose and filled it with love and pride.

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Preface

In my roles in the field of health as a professor, consultant, writer, health service administrator, and researcher, I became keenly aware of the need for cultural competence in health service administration and public health. My awareness actually peaked while teaching at a university in south Florida where a majority of the students (master's of public health and medical) and faculty were from the mainstream population in the United States. In exploring where many of the students planned to practice after completing their degrees, namely communities comprised of minorities (south Florida and most major cities in the United States are very diverse), discussions led to the fact that they had limited or no insight into the cultures of those they planned to serve and their curriculum did not address this deficit.

Consequently, as a faculty member, I was asked to develop a series of lectures on various aspects of culture to supplement the curriculum of the medical and public health students. This led to my exploration of the Culturally and Linguistically Appropriate Services (CLAS) standards in health care, which were released by the Office of Minority Health (OMH) of the Department of Health and Human Services (DHHS) in December of 2000 (OMH DHHS, 2000). Additionally, in an effort to further enhance my cultural knowledge and to gain more insight before, during, and after the cultural competence lectures, I traveled to many countries in Latin America (the Dominican Republic, Cuba, Puerto Rico [a US territory], Mexico), Central America (Costa Rica, Nicaragua, Guatemala, and Belize), the Caribbean (Jamaica, the Virgin Islands, the British Virgin Islands, and Aruba), Africa (Kenya, Senegal, South Africa, and the Cape Verde Isles), Fiji, Japan, Sri Lanka, and Europe (Spain, the Netherlands, Corsica, Portugal, France, and Italy). My travels and extensive study led to an enhanced understanding of various cultures and cultural nuances.

A particularly interesting turning point for me as I proceeded with this travel and study, was the reading of a book titled *The Spirit Catches You and You Fall Down* in which Fadiman (1997) states:

> There are no funds in the hospital budget specifically earmarked for interpreters, so the administration has detoured around that technicality by hiring Hmong lab assistants, nurse's aides, and transporters, who

> are called upon to translate in the scarce interstices between analyzing blood, emptying bedpans, and rolling postoperative patients around on gurneys. . . . Obstetricians have had to obtain consent for cesarean sections or episiotomies using embarrassed teenaged sons, who have learned English in school, as translators. Ten-year-old girls have had to translate discussions of whether or not a dying family member should be resuscitated. (p. 25)

The Spirit Catches You and You Fall Down is a compelling story of the suffering of a Hmong child with epilepsy within the American healthcare system. The incidents of linguistic and cultural incompetence that took place, negatively impacting the provision of health care for the child, are very disheartening. The idea that one's health care could be compromised because of a lack of understanding of one's culture and the inability to communicate with patients/clients/customers by healthcare and public health professionals seems implausible but is often a reality.

As described by Reynolds (2004):

> The care that Lin receives leads to misdiagnosis and eventual decline in health care status as a result of communication barriers and lack of understanding from both the Lee family and her providers. Fadiman's account allows the reader to begin to understand dimensions of the Hmong cultural identity and the challenges that the U.S. health care system faces in adequately addressing the health needs of a defined population. (p. 241)

Furthermore, the lack of cultural competence in health care and public health is not only a problem in terms of language barriers (linguistic competence) for people who arrive in the United States from other nations to seek care but is also a problem for Americans who are born and raised in the United States and who only speak English. Take my mother, for example. Many years ago (she is now deceased), she became gravely ill. One of her primary illnesses was diabetes. Her doctor and nutritionist strongly encouraged her to change her diet and were quite firm with her when she failed to comply. Her doctor and nutritionist requested that a family member accompany her for her next visit, and I was selected by my mother to escort her. During this visit, I explained to her doctor and nutritionist, upon hearing their concerns, that although she lived in New York City and had done so for most of her adult life, she had been reared in Georgia and, consequently, her diet was primarily soul food, which she preferred. I further explained that she enjoyed cooking and prepared meals based on recipes that had been passed on in her family for many generations. The doctor

and nutritionist asked me why she never told them this when they insisted that she change her diet. When I asked my mother why she did not tell them, she simply responded by saying, "They did not ask me." I proceeded to explain to the doctor and nutritionist, who were both white Americans, that soul food has a historical basis and was composed, in terms of its origin, of the remnants left by the slave masters after they ate the best parts of meat and the finest of all foods for their meals. The slaves took the scraps that were provided by their masters and turned them into tasty, highly seasoned dishes (often with a high salt content). Since my mother was an African American and a descendant of slaves, as most African Americans are, these dishes became a staple of her diet. The problem is that soul food is generally high in salt, fat, and sugar and includes frying as a mainstay of the preparation process. My suggestion to her doctor and nutritionist (as well as to my mother) was that she modify her diet rather than change it completely because the foods she ate and prepared were a significant cultural norm for her. Asking her to do otherwise was creating a serious cultural barrier and was leading to noncompliance, stress, and lack of communication that was exacerbating her overall health rather than helping her. This explanation helped in her care at the time because it promoted understanding and appreciation by her nutritionist and doctor regarding her food choices.

There is a great deal of miscommunication between patients/clients/customers and people in health care at various levels (staff and providers) and public health. The United States made a solid, concrete step toward improving the efficacy of health care and public health when, as mentioned earlier, the OMH released the CLAS standards. These 14 standards are guidelines, recommendations, and mandates aimed at ensuring that patients/clients/customers who seek care are treated with dignity, respect, and understanding in terms of their cultural and linguistic needs.

In reviewing these standards and other relevant topics and relating the information specifically to health services administration and public health, I have attempted to make this book, which provides an overview of cultural competence, a comfortable read with straightforward, comprehensible, and specific details. I believe that there are specific and important responsibilities that health service administrators and public health practitioners must meet in the provision of service and information. Therefore, it is imperative that healthcare executives and public health practitioners develop plans and initiatives to ensure that this occurs.

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Acknowledgments

I came to realize during the writing of this textbook that the saying "no man is an island," or in this case "no woman is an island," is a valid statement. To that end, I would like to acknowledge my gratitude to a number of individuals who made this work possible. First, I begin with Vincent Omachanu, who provided excellent expertise for the establishment of reliability and validity of the cultural competence assessment surveys that comprise the first three appendices of this book. His expertise during our work on the survey project was offered with kind and expert assurance, and I thank him for that. I would also like to thank my colleague, Dr. Anthony Munroe, the former CEO of Economic Opportunity Family Health Center, Inc., in Miami, Florida, now aptly entitled the Jessie Trice Center for Community Health. During my tenure at the center as a Cultural Competence Consultant and subsequently as Vice President of Behavioral Health Services, I was able to implement a cultural competence action plan with his approval and with an excellent administrative team. This was an excellent opportunity to see the positive impact that cultural competence has when implemented correctly by health services administration and the implications for public health organizations.

Additionally, I would like to express my thanks to Dr. Edmund Abaka, Director of the Africana Studies Program at the University of Miami. Through his efforts to expand the program and create a rich learning experience for students, he offered the opportunity for the development of new courses that I was ready and willing to handle in the capacity of adjunct and then visiting assistant professor, a role that I currently hold in his program along with a joint appointment in American Studies. The new courses that are relevant to this text are *Black Women in Medicine and Healing*, *Race and Health Care in America*, and *Culture, Race and Diversity*. These courses enable discourse around the topic of cultural competence with an opportunity to provide insight to interested and enthusiastic students. I also thank my former research assistants, Stephanie Fenton and Paulo Pires, for their efforts. I am grateful for their assistance and acquisition of information relevant to this text.

I am grateful to Dr. Patrick Williams, who served as a sounding board, encourager, and ardent taskmaster. His understanding of the process of preparing this text was profound because he was completing his dissertation

at the University of Miami at the time of my writing, so there was substantial opportunity for critical analysis based on similar intellectual tasks. Furthermore, I express my great appreciation to my excellent Barry University health services administration students, namely the Miami Children's Hospital cohort, for their excellence in my seminar course entitled *Cultural Competence in Health Services Administration*, a new course that I was asked to develop and teach. It enabled intense discourse on the subject of cultural competence and the opportunity to delve deeply with health service administrators who have the capacity to implement cultural competence initiatives in their work environment. Hence, I want to thank Dr. Alan Whiteman, Chair of the Department of Health Services Administration, for affording the opportunity for me to teach such outstanding master's level students.

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Lastly, and with the highest regard, I thank God, without whom nothing I achieve would be possible.

About the Author

Dr. Patti Rose acquired her Master's Degree (MPH) in Health Services Administration from the Yale University School of Public Health followed by her Doctorate (EdD) in Health Education from Columbia University, Teachers College. She is currently a Visiting Assistant Professor for the University of Miami (UM) Africana and American Studies Programs for which she has developed new courses entitled *Black Women in Medicine and Healing*, *Race and Healthcare in America*, *African Women in the Diaspora*, and *Contemporary Issues in America*. Formerly, she served as CEO of Rose Consulting, Inc., followed by CEO of Plainfield Health Center in Plainfield, NJ. Prior to that she served as Vice President of Behavioral Health Services at Economic Opportunity Family Health Center (EOFHC), Inc., one of the largest community health centers in the nation, located in Miami, FL, and as a consultant for EOFHC. She has also held the title of Lecturer for the Yale University School of Public Health, Adjunct Professor for the UM Education Department and Executive MBA Program and for the Barry University Health Services Administration Program, Associate Professor at Nova Southeastern University in Fort Lauderdale, FL, and Assistant Professor at Florida International University in Miami, FL (graduate level public health programs). Her professional affiliations have included the American College of Health Care Executives, the American Public Health Association, the Black Executive Forum, and the National Association of Health Services Executives. She was inducted into the Public Health Service Honor Roll at the Yale University School of Public Health for her long-term commitment to public health service and was appointed by the US Department of Commerce, National Institute of Standards and Technology to serve in the capacity of Examiner on the 2004 Board of Examiners of the Malcolm Baldrige National Quality Award. Dr. Rose has been married for 24 years and is the mother of two young adults.