

Evaluation of a New Cultural Competency Training Program: CARE Columbus

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Purpose: This article reports the educational outcomes of the newly developed CARE (Cultural Awareness and Respect Through Education) Columbus cultural competency training program.

Methods: Questionnaires were administered to course participants, who completed the 3-hour CARE Columbus cultural competency training program from March 17, 2006, to April 18, 2008. A pilot work site implementation questionnaire was also sent to a smaller sample of participants who completed the course.

Results: The CARE Columbus cultural competency training received an overall program rating of 4.5 on a 5-point scale. Sixty-three percent (379 of 601) of the participants completed the program questionnaires. In addition, 55% (33 of 60) of the pilot work site implementation questionnaires were completed.

Conclusion: Initial evaluation of the CARE Columbus cultural competency training program appears to demonstrate its effectiveness in improving attitudes, knowledge, and skills. Expanded evaluation to include determination of how best to overcome work site implementation barriers is warranted. Future challenges include development of an optimal business plan to maintain sustainability and improve outreach of CARE Columbus and similar classroom style training programs.

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INTRODUCTION

Overcoming cultural and linguistic barriers to effective health care presents a major challenge for medical educators, health systems, and policy makers.¹⁻³ Cultural and linguistic barriers such as health care provider bias and lack of training concerning appropriate use of interpreters may negatively impact

the patient-physician therapeutic relationship and lead to suboptimal health care.¹⁻³ The Institute of Medicine (IOM) reported that education may be one of the most important tools to help eliminate health care disparities and that all current and future health care providers can benefit from cross-cultural education.³

Central Ohio has been challenged by its growing diversity. For example, ineffective communication and suboptimal patient-physician relationships may have led to refusal of some Somali immigrant women to undergo emergency cesarean section. This refusal ultimately resulted in preventable fetal deaths. In 2002, in response to health care challenges caused by the growing diversity of central Ohio, the CARE (Consider, Accept, Recognize, and Execute) model of building cultural competence in health care was developed through a partnership with Access Health Columbus, United Way of Central Ohio, and Global Lead Management Consultants. Several culture-based and other community organizations in central Ohio also provided curriculum guidance and content review. These organizations included the Asian American Community Services, Cambodian Mutual Assistance Association, Capital University School of Nursing, Nationwide Children's Hospital, Columbus Public Health, Columbus State Community College, Columbus Urban League, Ohio Health, Jewish Family Services, Ohio Hispanic Coalition, The Ohio State University Medical Center, Somali Community Association of Ohio, and the Somali Women's Association.

Cultural competence was defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations.⁴

Interlocking principles that form the foundation of the CARE model include:

1. **Consider** and reflect on the patients'/clients' health and cultural issues and concerns. When we consider and reflect on culturally competent health care, we should ask ourselves:
 - What are the issues that are helping or hindering the successful delivery of culturally competent care?

- What is causing discomfort in the patient–health care provider relationship?
- What are the common goals between patients and health care providers?

2. **Accept** and understand that patients’/clients’ cultural differences, practices, and perspectives will impact their health care experience. As we search for acceptance and understanding of the dynamics of culturally competent health care, we should ask ourselves:

- What aspects of providing culturally competent care might be a source of friction?
- What characteristics from patients’ culture may be similar and/or different than mainstream American culture?

3. **Recognize** and build familiarity with individual patients’/clients’ cultural norms, beliefs, and attitudes towards health care. As we begin to recognize and build familiarity and comfort, we should ask ourselves:

- What are the guiding principles and actions that can begin to build familiarity and comfort within the patient–health care provider relationship?
- What are the potential connections that can be established?

4. **Execute** a proactive, culturally sensitive health care intervention that supports patients’/clients’ recovery and respects their cultural values without compromising the quality of their health care and medical treatment. As we initiate a proactive cultural competency action plan we should collectively:

- Discuss common goals and ways to work together that will increase comfort and make relationships better.
- Recognize and appreciate the effort to connect.

Trained facilitators presented CARE Columbus in an introductory curriculum entitled “Building Cross-Cultural Competency in Healthcare.” From March 17, 2006, to April 18, 2008, CARE Columbus trained 601 participants from the health care and social work fields. The interactive course format included: (1) an overview of the curriculum development process; (2) completion of CARE exercises to affect attitudes, knowledge, and skills: “Consider—exercise” instructs trainees about assumptions and intercultural hooks that block communication, “Accept—exercise” instructs trainees about aspects of culture that impact the health care setting, “Recognize—exercise” instructs trainees about

behaviors of a culturally competent health care provider, “Execute—exercise” instructs trainees how to give directions/explanations in culturally sensitive ways and how to conduct culturally sensitive medical interviews; (3) review of literature concerning best practices for culturally competent care and review of culturally and linguistically appropriate services (CLAS) standards; (4) review of findings from focus groups comprised of members of the African American, Asian, Hispanic, Russian, and Somali residents of central Ohio; and (5) a work site action plan exercise.

The purpose of this study was to (1) describe how the CARE Columbus program has addressed the challenges of diversity, (2) demonstrate the program’s effectiveness through data analysis of 2 surveys, and (3) explore the implications of this research for other cultural competency programs.

METHODS

The 601 participants attending these sessions included physicians, nurses, public health educators and program coordinators, licensed social workers, health care and human services support staff, and administrators. To present the curriculum, CARE Columbus contracted with experienced and qualified trainers/facilitators who brought extensive health care, human services, and education experience to the program.

The participants were asked to anonymously complete questionnaires following completion of the 3-hour level 1 CARE training program. In addition, a pilot work site implementation questionnaire was sent to 60 participants via a Survey Monkey secure e-mail system 6 weeks after completion of the CARE training. Both questionnaires were institutional review board exempt.

Table 1. Occupation and Tenure of Participants

	N = 379
Occupation	
Administrator	43
LSW/LISW (social workers)	66
Physician	9
Other nursing staff	15
Registered nurse	72
Other	88
Support staff	27
Did not answer	59
Gender	
Female	281
Male	56
Did not answer	42
Tenure, y	
<1	17
1-5	60
5-10	45
≥10	203
Did not answer	54

RESULTS

Questionnaires were completed by 63% (379 of 601) of the participants immediately following the CARE training session, with an overall rating of 4.5 on a 5-point scale (Tables 1 and 2). In addition, 55% (33 of 60) of the work site implementation questionnaires sent out 6 weeks after completion of the course were completed via the Survey Monkey secure e-mail system (Table 3).

Participants were also asked to provide comments on the strengths and/or weaknesses of the CARE Columbus training. The comments were reviewed and grouped into the following categories. Comments of particular note were included verbatim:

Self-report of change in attitudes and knowledge

- “As a physician, this gave me more tools/information to use to encourage administrative buy-in and encourage me to push forward to demand appropriate support in my work setting.”
- “I believe (the trainer) provided some common sense suggestions on how to address cultural competency. I also found the exercises done were valuable. I will use a few of them to help sensitize my staff.”
- “This was a comfortable training. The trainer did not make anyone feel that their answer was wrong. Opened me up to the barriers we face.”

Table 2. CARE Training Program Questionnaire

Evaluation N = 379 of 601 (63%)	(1-5)
1. Trainer's knowledge of cultural competency? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Poor Satisfactory Excellent	4.80
2. Clarity of the presentation? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Poor Satisfactory Excellent	4.78
3. As a result of the training, are you able to:	
a. Describe the imperatives for increasing cultural competency in health care? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Absolutely	4.49
b. Examine your own personal level(s) of cultural competency? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Absolutely	4.37
c. Review and discuss C.A.R.E., a tool for increasing cultural competence in health care setting? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Quite a lot	4.46
d. Practice the C.A.R.E. model? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Quite a lot	4.44
e. Develop functional mastery in delivering culturally competent care to Central Ohio patient base? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Quite a lot	4.00
4. The purpose of this training was to provide culturally competent patient care strategies and skill-building exercises for health care professionals:	
a. Did we meet the objectives? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Quite a lot	4.50
b. How effective were the teaching methods used by the trainer? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Quite a lot	4.65
c. How well were your personal objectives for attending this training met? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Not at all Somewhat Quite a lot	4.43

- “This was a great learning experience. I felt that this will help me in my everyday experiences.”
- “I began knowing very little and at least now I have a base of knowledge to take back to my workplace.”
- “I am going to become a good listener.”
- “Very helpful. I thought I knew so much about this topic. I learned much more than I thought—mostly about myself.”

Suggested improvements

- “I hope you could give this in ‘miniforum’ to workplaces for diversity training.”
- “Specific cultural differences listed as a general guide would have been helpful.”
- “Actual implementation of a cultural competency program.”
- “Would like more information about nonminority cultures: deaf, disabled, generational, lesbian/gay/bisexual/transgender [LGBT]...”
- “CLAS standards—how to implement them?”
- “Workplace issues for dealing with others.”
- “I understand the importance of cultural training, but there was little to no talk about Caucasian culture.”
- “Too much group work—took away from the material that was presented.”

The majority of time-related comments called for extending the training by at least an hour; 6 participants suggested an all-day session.

Additional time-related requests dealt specifically with the curriculum:

Length of training

- “Recommend spending less time on intro and other facts so more time can be spent on CARE [model].”
- “Need more time for case study and interactive process to...help develop skills.”
- “This was a very good intro to becoming culturally competent. However, more time and training should be provided to assist the

employees to a more effective and efficient job on a day-to-day basis.”

- “The class was way too basic. Could have been taught in an hour.”

Other comments of note

- “This training should be mandatory for all local, state, and federally elected officials—anyone who influences health care legislation.”
- “Professionals that attended were above information. \$45 was too much to charge for one idea: CARE.”
- “Really appreciated the variety of media used to further education or teach. Looking forward to part II.”

DISCUSSION

The population of central Ohio continues to grow, displaying an estimated 5.6% increase⁵ from 2000 to 2008. Since 2000, international immigration has accounted for 82% of central Ohio’s population growth, with an average of 105 foreign-born immigrants migrating to central Ohio each week.⁶ In addition, 9% of central Ohioans speak a language other than English at home.⁶

Furthermore, throughout the United States there are barriers limiting the effectiveness of care provided to individuals from the LGBT community.⁷ Approximately 3% to 6% of patients self-identify as LGBT, and public health interventions and goals have been published in the *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual and Transgender Health*.^{7,8}

CARE Columbus represents the collaborative effort of central Ohio philanthropic and community organizations to meet the cultural and linguistic needs of its increasingly diverse population. The high rate of positive evaluation (4.5 on a scale from 1-5) shows that although the participants had been professionals in their fields for several years and had reported an average of “some” previous cultural competence training, these professionals still reported an improvement in their knowledge base and skill as a result of this introductory training.

The quantitative data show that the rate of workplace

Table 3. Work Site Implementation Questionnaire

Question	Response	No.
Developed work site action plan? N = 33 of 60 (55%)	Yes	23
	No	10
Action plan implemented? N = 23 of 60 (38%)	Yes	13
	No	10
Recommendations for expanded content focus (may select more than 1 answer) N = 33 of 60 (55%)	Spirituality and religion	16
	Culture specific	20
	Disease specific	20
	Working with interpreters	9
	Culturally and linguistically appropriate services standards	8

implementation was about 39% (13 of 33). The lower rate of participation in this work site implementation questionnaire limits our ability to generalize the data. Additional work site implementation questionnaires will be necessary to demonstrate work site efficacy related to CARE Columbus training. Future questionnaires should include questions concerning work site implementation barriers and strategies used to overcome those barriers.

The self-perceived improvement in attitudes, knowledge, and skills are also consistent with the findings of other cultural competency training programs.⁹ Expanding the program to include longitudinal opportunities for continued training may be required to address the lowest rated outcome of the course evaluation: Development of functional mastery in delivering culturally competent care to central Ohio patient base (4 on a scale from 1 to 5).

In regards to suggestions for improvement of the CARE Columbus curriculum, overall, 55% of trainees recommended greater focus on culture-specific content. However, this may be representative of the fact that CARE Columbus tries to prevent stereotyping by focusing on relationship-centered interactions rather than focusing on a list of facts associated with certain members of various demographic groups. Further clarification of this relationship-centered approach and more emphasis in discussion about appropriate ways to use culture specific data, including LGBT information, appear to be warranted. In addition, the impact of such change would need to be evaluated via questionnaire. The highest rated outcomes for the CARE Columbus course evaluation speak to the quality of the trainers: (1) trainer's knowledge of cultural competency (4.80); and (2) clarity of the presentation (4.78), representing strengths to build upon as the program undergoes continual quality improvement based on constructive feedback.

Implications for CARE Columbus and Other Cultural Competence Programs

Although cultural competency training provides a valuable resource for health care systems, the per-person registration cost of \$45 to receive training may limit program enrollment. Competition also exists in the form of free online cultural competency training programs such as the Department of Health and Human Services, Office for Minority Health's Think Cultural Health (www.thinkculturalhealth.org/).

In addition, comparative studies evaluating the effectiveness of different methods of training and combinations of those methods need to be conducted. For

example, should online training serve as a stand-alone method of training, or is there a measurable significant benefit to supplementing online training with classroom training or vice versa?

CONCLUSION

Initial evaluation of the CARE Columbus cultural competency training program appears to demonstrate its effectiveness in improving attitudes, knowledge, and skills. Expanded evaluation to include determination of how best to overcome worksite implementation barriers is warranted. In addition, future challenges include development of an optimal business plan to maintain sustainability and improve outreach of CARE Columbus and similar classroom style cultural competency training programs.

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