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Teaching Cultural Competence in Allied Health Professions in California

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Background

In recent years there has been a great deal of attention toward training the health care workforce to be culturally competent. However, cultural competence may mean different things to different stakeholders, such as patients, health care professionals, educators, and the health care delivery system. Cultural competence has been defined in numerous ways. Many current definitions are variations of one developed several years ago stating that, "cultural competence is a set of congruent behaviors, attitudes, and policies that enable systems, agencies, and professionals to work effectively in cross-cultural situations."[i]

Brach and Fraser further describe cultural competence as including linguistic competence. They state that culturally competent practitioners must move beyond cultural awareness or sensitivity toward having a set of skills and being able to use them in cross-cultural situations.[ii]

The effort to diversify the health care workforce is also linked to cultural competence. Studies suggest that a diverse workforce is more likely to provide culturally competent care and ultimately reduce health disparities in the population.[iii]

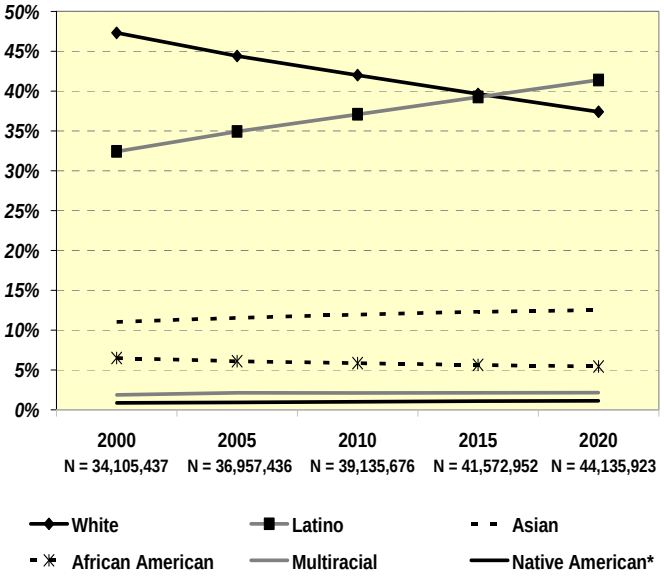
While a multifaceted approach is needed to address cultural competence in health care systems, the training of health professionals is a key component.

Brach and Fraser describe three goals of training in cultural competence, including enhancing self-awareness of attitudes, increasing knowledge about populations, and improving skills such as communication.[iv] Training can be part of an undergraduate or graduate health professions education program or take place during in-service education programs.

O'Neil states that the health care field needs to continue to discuss and develop a commonly understood framework for cultural competence.[v] There are several dichotomies in the current thinking about cultural competence and how one best learns those skills. One common approach is a knowledge-based paradigm that involves learning about and understanding unique cultures in order to better appreciate and communicate with patients from another culture. Another, more experiential, method of learning focuses on the relationship between the health professional and the patient. Both components are necessary, yet health care workforce training has often focused on only the first component.

It is not difficult to make the case for the importance of cultural competence training for allied health professionals in California. Currently, about 20% of the general population in the state and about 25% of school age children have limited English proficiency.[vi] Projections for California's future population displayed in Figure 1 clearly show that the state is already multicultural and will become increasingly more so over the next decades.

Figure 1. Population Projections for California 2000-2050



Source: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050.* Sacramento, CA, July 2007.

Purpose

Our purpose in this analysis was to assess the availability of cultural competence curricula in allied health programs in California. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) and several other allied health accrediting bodies require that cultural competence be included in the curriculum. However, there has been little information available to assess the extent of compliance with these requirements or what types of courses are offered.

Data Collection

We analyzed 2005 data collected on allied health programs in California for the *American Medical Association (AMA) Health Professions Career and Education Directory*. The AMA used an online survey to collect data on health professions education programs throughout the U.S. for the 2004-2005 academic year.[vii]

The AMA has collected and published information on allied health education programs since the 1960s. Its annual survey requests data on both students and programs. Data items include enrollment, attrition, and graduation rates; program length, degree offered, program capacity, and numerous other elements. Beginning with the 2002 survey, two additional items were included on the survey: the availability of education/courses in medical/health care terms in non-English languages, and the availability of education in cultural competence or patient communication.[1] In addition, respondents were asked to provide any additional comments describing the specific content or courses dealing with these two subjects.

In California, the AMA surveyed 342 allied health programs in 2005. There were 195 programs responding (57%). AMA methodology also counts data collected for two prior survey cycles, with 38 additional programs responding for 2004, and 13 additional programs for 2003. Adding these 51 programs to the total respondents increases the response rate to 72% (246 out of 342 responding).

A limitation of this data is that not all programs respond to the AMA survey, and that 15% of respondents are from prior years' survey cycles (i.e., 2003 and 2004). The online survey may not capture details of a particular program's involvement in and commitment to cultural competence training for programs that did not provide comments. However, we believe the response rate and the detailed comments on course content provide a rich understanding of current efforts in this regard.

Survey Findings

Of the 342 allied health programs in California surveyed by the AMA, 37.5 % stated that they offer education in cultural competence or patient communication. Table 1 includes information by program type, including the total number of programs and the number and percent of total for those offering cultural competence content. By program type, the responses ranged from 1-100 %. There are several professions with three or fewer total programs in the state, so comparisons using only the percentage information may not be as useful. Professions for which every program in the state reported cultural competence content included art therapist, clinical laboratory technician/medical laboratory technician, genetic counselor, health information administrator, massage therapist, occupational therapy assistant, orthoptist, and phlebotomist.

We also analyzed responses by school and region to determine whether the tendency to include cultural competence curriculum would be the same across

[1] Cultural competency and patient communication were included together in a single survey item

Table 1. Types of Allied Health Education Programs Incorporating Cultural Competence in the Curriculum

Type of Program	Number of Programs in CA	Number with Cultural Com-petence	Percent of Programs Respon-ding "Yes"
Art Therapist	3	3	100.0
Clinical Laboratory Technician	2	2	100.0
Genetic Counselor	2	2	100.0
Health Information Administrator	1	1	100.0
Massage Therapist	1	1	100.0
Occupational Therapist Assistant	4	4	100.0
Orthoptist	1	1	100.0
Phlebotomist	2	2	100.0
Occupational Therapist	6	5	83.3
Physical Therapist	13	9	69.2
Cardiovascular Tech	3	2	66.7
Rehabilitation Counselor	6	4	66.6
Radiographer	31	20	64.5
Physician Assistant	10	6	60.0
Orientation and Mobility Specialist	2	1	50.0
Radiation Therapist	4	2	50.0
Speech-Language Pathologist	14	6	42.8
Medical Assistant	26	11	42.3
Respiratory Therapist	19	7	36.8
Counselor	6	2	33.3
Diagnostic Medical Sonographer	6	2	33.3
Music Therapist	3	1	33.3
Physical Therapist Assistant	6	2	33.3
Respiratory Therapist (Entry level)	6	2	33.3
Therapeutic Recreation Specialist	3	1	33.3
Dental Hygienist	20	6	30.0
Clinical Laboratory Scientist	8	2	25.0
Nuclear Medicine Technologist	4	1	25.0
Pharmacy Technician	21	5	23.8
Dental Assistant	25	5	20.0
Surgical Technologist	21	4	19.1
Audiologist	6	1	16.7
EMT/Paramedic	25	4	16.0
Health Information Technician	9	1	11.1
Athletic Trainer	12	1	8.3
Cytotechnologist	2	0	0.0
Dental Laboratory Technician	2	0	0.0
Electroneurodiagnostic Technologist	1	0	0.0
Histotechnician	1	0	0.0
Kinesiotherapist	2	0	0.0
Orthotist/Prosthetist	2	0	0.0
TOTAL	**341**	**128**	**37.5**

Source: AMA Data, 2004-2005 academic year

programs in the same educational institution or whether there was any geographic concentration of programs. The survey data showed no clear pattern for schools offering cultural competence curriculum. Program content was offered in schools throughout all regions in the state but not uniformly across programs. Findings indicated that there were more similarities across program types than across institutions. This is likely a reflection of the characteristics and required competencies of a given profession versus another. For example, a profession with little or no patient contact (e.g., health information technician) would have different educational competencies and job requirements than one with a greater degree of clinical interaction (e.g., occupational therapist).

Comments on Course Content

As noted in the methods section, programs were invited to include comments on the survey regarding how cultural competence was incorporated into the curriculum. Many programs provided a brief description or the name of the course or content that referred to cultural competence.

Of the programs responding with comments, most mentioned specific courses that included content on communications or cultural competence. Other programs responded to the item with examples of courses taught in other languages, predominantly Spanish. A few respondents named ethics courses and a few referred to case study approaches. About 30 programs responded that cultural competence was integrated throughout the curriculum.
We selected a sample of 20 out of the 115 programs that included comments for an in-depth review. Programs were chosen to reflect a variety of institution types (state university, private, and community college), health professions, and degree levels. We then explored their curricula by examining course catalogs and other data available on the schools' websites. Of these, we were able to obtain information for 18; 10 are either undergraduate or certificate-granting programs, 6 provide graduate-level education, and 2 award both undergraduate and graduate degrees.

In many cases cultural competence courses are required as part of general education requirements, particularly at the undergraduate level. All but one of the 12 undergraduate or certificate-granting programs have a general education category that focuses specifically on multiculturalism and diversity; the remaining school has a language and humanities requirement. Students must complete a stated number of units (ranging from 3 to 6) in that category and can select from a number of courses.

Classes that satisfy the general education diversity category range from general to those that specifically address cultural competence. A myriad of courses (music, history, and literature to name a few) are included under this heading. However, these courses do not address how to become a culturally sensitive health provider. The most specific courses we found incorporate language with healthcare. For example, in the Health Care Service Learning in a Chinese Context class in one dental hygiene program, students engage in language and cultural immersion and gain practical skills while serving the needs of the public.[viii] Another program offers two courses that teach conversational Spanish to develop patient-physician relationships.[ix]

The specific health program curriculum aside from general education is where one might expect to see more content on cultural competency. However, this is not necessarily the case and appears to depend on the amount of patient interaction required of the profession. For example, a private university program in dental hygiene has three relevant classes and a community college program we reviewed had two. However, in two other programs we examined, neither a state university program in radiologic sciences nor a community college radiology technology program was found to have courses with cultural competence content in its health program curriculum.

The seven graduate programs we investigated were for professions that necessitate a high degree of interpersonal communication, for example, physical therapist and speech-language pathologist. As might be expected, these Master's and Doctorate-level programs have a great deal of culturally competent-specific content. In addition, multiple hours of clinical experience in the field must be completed before graduation. Two programs incorporate cultural awareness into the course descriptions: one stipulates that students must complete a minimum of 25 hours of fieldwork with a client who is determined to be from a language or dialect different from that of the student;[x] the other, a physician assistant Master's program, states that field experience will give the student the opportunity to explore how cultural considerations, among other factors, affect treatment outcomes and utilization of services.[xi]

Summary and Policy Implications

In summary, many programs seem to incorporate some courses on culture into their curricula, whether it is through General Education or profession-specific coursework. In this analysis we could not assess whether students might have been exposed to cultural competence training through meeting general education requirements prior to enrollment in a health professions program.

A third of the allied health education programs in California offer some type of content in cultural competence. There is a great deal of variation in the number and type of courses by type of program and educational institution. This analysis did not allow us to evaluate any detail about the courses or specific content included. However, the presence of these courses reflects the first step: awareness and sensitivity of the institutions to cultural considerations. The fact that there is such a great range of inclusion of cultural competency courses would indicate that a standard resource of best practices for cultural competence in the allied health sector may be worth considering. The next step is to assess how well the goal is being met for producing a culturally competent workforce and whether there are lessons and best practices to be shared among schools and programs.

Ultimately, creating a workforce that is truly culturally competent will require a more substantial transformation of the current health education and care delivery system. The allied health education programs in California are taking important steps toward cultural competence but must continue and expand the effort to reach more programs. Integrating cultural competence throughout the curriculum and providing experiential learning will require resources and commitment from all stakeholders.

Acknowledgements

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