

**CULTURE COMPETENCY TRAINING: ACCESS, UTILIZATION  
AND CONTENT**

**A SURVEY OF PUBLIC HEALTH PRACTITIONERS IN IOWA**

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## TABLE OF CONTENTS

EXECUTIVE SUMMARY .....	2
INTRODUCTION.....	4
METHODOLOGY.....	6
RESPONDENT DEMOGRAPHICS .....	6
RESULTS.....	8
CONCLUSION.....	21
RECOMMENDATIONS.....	22
NEXT STEPS.....	23

## APPENDIX

I. OPEN-ENDED QUESTIONS.....	24
II. DATA COMPARISON TABLES.....	27
III. LOCAL PUBLIC HEALTH DEPARTMENT OF RESPONDENTS.....	32
WORKS CITED.....	34

## EXECUTIVE SUMMARY

### Background

The main objective of the Culture Competency Training survey was to determine whether Iowa's public health practitioners routinely seek training opportunities in the area of cultural competence and the delivery modality of current training. An announcement about the survey was distributed to the target audience using multiple listservs. The survey was available via SurveyMonkey between Friday, March 26 and Monday, April 19. During this time, 363 public health practitioners participated in the survey. Of those responding 65% were from either local or state public health departments. In looking at how long respondents had been at their current agency, 40% had been at their agency ten or more years, while 28% had been at their agency between 1 – 3 years. Fifty percent of respondents were college graduates. Respondents came from a wide variety of disciplines.

### Results

Among survey respondents, 81% had been offered the opportunity to participate in a cultural competency training session and 75% had completed at least one session. The greatest number of respondents reported attending an office-based training conducted by a guest speaker, followed by an off-site training in Iowa and an office-based training conducted by agency staff. Respondents who had the opportunity to participate in trainings but did not do so listed lack of convenience and accessibility as reasons.

Survey respondents reported that when enrolling in future cultural competency trainings their preferred way to access trainings is via the internet, from office-based guest speakers, and at a conference in the local community or within Iowa. These responses reflect an interest in convenient, accessible trainings as well as a desire to learn from field experts rather than agency staff.

Survey results indicate there is room for improvement among existing cultural competency trainings related to cultural awareness, cross-cultural communication skills, and cultural knowledge content. While respondents who had completed cultural competency trainings reported higher rates of positive responses in all three of these areas, the survey results indicate that some existing trainings do not adequately or effectively address these topics. Slightly more than half of respondents have access to books, videos, and other websites and resources at their agency to enhance their knowledge about the clients they serve. Respondents who have access to such resources report high rates of utilization, while respondents without such tools indicate they believe these resources would be useful for their agency.

The study results also indicate that public health practitioners in the state do not typically complete organizational- and self-assessments. The culture within public health agencies may impact the leadership and staff's approach to cultural competency training. Preliminary analyses indicate that agencies where staff do not have the opportunity to participate in cultural competency training are also less likely to have assessed their progress in serving diverse clientele and to have policies in place that address diversity and cultural competency.

Respondents also had the opportunity to share in several open-ended questions the challenges they face and the solutions they envision to providing culturally confident public health care in their communities. Respondents overwhelmingly cited language as a significant challenge and the increased use of interpreters and translators as a potential solution.

Respondents expressed a desire to attend additional convenient and high quality training sessions on cultural competency as well as a desire to learn more about diverse cultures and the health related problems they face. Respondents expressed a desire to create partnerships and networks to improve their culture competency and an interest in involving community residents in the planning, implementation, and evaluation of their public health initiatives. They also expressed a desire to recruit and retain a more diverse public health workforce.

### **Recommendations:**

- **Web-based cultural competency training**
  - Public health practitioners would like additional training in cultural competency trainings that are accessible, affordable, and focus on cross-cultural communication skills, cultural awareness and cultural knowledge
  - To supplement recommended trainings, the Iowa Center on Health Disparities might consider creating a short, web-based training with specific information on Iowa's prominent cultures
  - Guidelines on the frequency of training should be developed
  - Training should be completed during the orientation period for new employees
- **Leadership training**
  - Training tailored to agency leadership may help leaders recognize the importance of organizational- and individual employee-cultural competence and encourage them to ignite change in the field of public health
  - Training could also provide guidance to agency leaders on how to “reach out” to their communities through advisory groups, focus groups, and community needs assessments, etc.
    - Involving local cultural groups at all levels of public health initiatives is known to improve the engagement and participation rates by clients and create positive impacts on health outcomes.
  - Trainings could also serve as a forum to create desired partnerships and translator databases recommended by respondents
- **Address language barriers**
  - The survey results suggest a significant need for language resources across the state, including access to the Language Line, interpreters and translators
  - Create partnerships and/or a database to improve access to translators
  - Provide policy recommendations related to language barriers

### **Next steps:**

- Disseminate recommendations of Environmental Scan via the Institute for Public Health Practice Public Health Toolkit
- Establish timeline and training guidelines to assist individuals and agencies to begin to be more consistent and deliberate in what is offered for public health practitioners
- Consider organizing/conducting training for agency leadership on cultural competence and community outreach
- Consider partnerships to address language challenges and workforce diversity
- Share this report with other State Departments, organizations and/or coalitions that may benefit from having this data. This may also result in more intentional partnerships across departments that can ultimately work to meet the needs within Iowa communities.

## **INTRODUCTION**

The Culture Competency Training: Access, Utilization and Content survey was jointly funded by the Iowa Department of Public Health (IDPH), Bureau of Health Care Access, State Office of Rural Health and the University of Iowa College of Public Health, Upper Midwest Public Health Training Center (UMPHTC). UMPHTC provides education and training on the latest public health techniques and practices in Iowa, Nebraska, and South Dakota.

The UMPHTC Iowa Advisory Committee is comprised of representatives from academia, state and county health departments, non-profit organizations, private agencies, and the State Hygienic Laboratory at the University of Iowa and provides guidance on identifying workforce development needs. In 2008, the Iowa Advisory Committee identified cultural competency as an area of need and formed the Cultural Competency workgroup. In January 2010, the Cultural Competency workgroup, facilitated by Dawn Gentsch, hired a Student Intern to help them determine whether Iowa's local public health practitioners are obtaining training and education in the area of cultural competency. The internship objectives included:

- determining the common delivery modalities of current trainings
- identifying any gaps in the content and quality of the training resources currently being utilized
- conducting a review (Environmental Scan) of the cultural competency resources available in Iowa and across the nation

Key informant interviews were conducted with Cultural Competency workgroup members Marilyn Alger, Janice Edmunds-Wells, and Julie Blum to determine the survey's scope and objectives. The final content and organization of the survey were reviewed by workgroup members and Tanya Uden-Holman, Director, Upper Midwest Public Health Training Center. Sielinde Prior, who interned at IDPH in 2003 and conducted a study to determine the need for enhanced linguistic and cultural services in all state departments, was also contacted. Although her report, "Interpretation and Translation Needs and Resources within Iowa State Government" relates to this project, the survey conducted for this internship is more general in scope. Dawn Gentsch served as the preceptor and supervisor for the internship and guided the development, dissemination, and analysis of the survey.

The survey findings will be used to identify areas of need in cultural competency training, inform future continuing education and competency-based training initiatives, and guide the Regional Multi-Cultural Health Coalitions being established by IDPH. They will also be shared with other public health stakeholders throughout the state and various health reform committees that IDPH oversees in order to provide an additional level of data that supports their work to reach vulnerable and special populations.

## **CULTURAL COMPETENCY: DEFINITION AND MODELS**

Cultural and linguistic competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (OMH, 2005). 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (OMH, 2005). 'Competence' implies having the capacity to function effectively as an individual and an organization within the

context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (OMH, 2005). Cultural competency is often associated with minorities' access to quality health care and has been recognized as a means of "closing the disparities gap in health care" (OMH, 2005). Cultural competency is also associated with providing health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.

Cultural competency training is not only important for physicians and health care providers, but also for public health practitioners who design, implement, and evaluate health education, health promotion and disease prevention interventions and materials. The background research led us to focus not only on culture as defined by race, language, and ethnicity, but also on culture as it relates to age, religion, gender, sexuality, and socioeconomic status. Throughout this report, "training" will be used to describe any formal learning or professional development opportunity and may take place within or outside of the agency setting, including workshops, seminars, and conferences.

Although many models of cultural competency were reviewed it was determined that the Tools for Accessing Cultural Competency Training (TACCT) developed by the Association of American Medical Colleges and the model developed by Josepha Campinha-Bacote in "The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care" were most applicable. Both models stress that cultural competency is not a skill that can be learned in one lesson but rather an ongoing process in which the practitioner should continuously strive to improve their ability to work effectively with diverse clients.

TACCT suggests that cultural competency training programs should include the rationale and definition of cultural competency, the impact that stereotyping can have on clients, health disparities, and cross-cultural communication skills (AAMC, 2005). Campinha-Bacote's model emphasizes awareness of one's own culture, knowledge about diverse cultural groups, cross-cultural communication skills, direct cross-cultural interactions, social determinants of health and the motivation to become culturally competent (2002). The survey included items designed to determine whether these components of cultural competency are included in existing trainings.

Based on key informant interviews and reviewed examples of cultural competency training surveys, the decision was made to exclude phrases such as "cultural competency training" and "diversity training" from the title and content of this survey. The objective was for respondents to answer questions about any training they had attended that was related to the social, cultural, and ethnic issues around public health, not just those explicitly titled "cultural competency" training.

Respondents were also asked to "keep in mind the different needs of the people you serve (clients) based on a wide-range of individual characteristics including age, disability, ethnicity, gender, native language, national origin, race, religion, sexual orientation, etc." The objective was to encourage respondents to think not only about their ability to work with people from different racial, ethnic, and linguistic backgrounds, but also cultures that are not as often identified, like gender and age.

## **METHODOLOGY**

A combination of open- and closed-ended questions was used for a total of 22 questions. The web-based survey was posted on SurveyMonkey which was cost and time effective. A convenience sample of public health practitioners was utilized. Although using a non-probability sampling methodology does limit the ability to generalize the findings to all public health practitioners in the state, given more than 300 individuals responded the results still provide useful information.

UMPHTC's Cultural Competency workgroup and Iowa Advisory Committee members helped distribute the survey link to public health practitioners via email list serves. The following groups and individuals assisted with survey distribution.

- Iowa Counties Public Health Association—Graham Dameron
- Iowa Department of Public Health:
  - Julie McMahon - local public health agencies, public health nursing, and Community Health Consultants
  - Jane Borst - Title V Maternal and Child Health, child care consultants, and Title V family planning agencies.
  - Brenda Dobson - WIC program
  - Doreen Chamberlin - hospitals and other health care entities
  - Marilyn Alger- IDPH Divisions i.e. Tobacco, Environmental Health
- Iowa Environmental Health Association—Eric Bradley
- Iowa Nebraska Primary Care Association—Julie Blum
- Iowa Public Health Association—Jeneane Moody
- Iowa Rural Health Association—Gloria Vermie
- Partnership for Better Health
- State Hygienic Laboratory at the University of Iowa—Beth Hochstedler
- UMPHTC Iowa Advisory Committee— Laurie Walkner

The survey was open to respondents for 24 days between Friday, March 26 and Monday, April 19, 2010. During this time, 363 individuals began the survey and 325 surveys completed it for a completion rate of 89.5%.

The results of the survey were analyzed using the tools provided by Survey Monkey, including filtering responses and cross-tabs. Data were also exported into Excel so additional analyses could be completed. Basic descriptive statistics are used to present the survey results

## **RESPONDENT DEMOGRAPHICS**

Tables 1 – 4 present demographic data for the respondents. As indicated in Table 1 the majority of respondents (64%) were employed in either state or local public health. As shown in Table 2, in looking at how long respondents had been at their current agency, 40% had been at their agency ten or more years, while 28% had been at their agency between 1 – 3 years. These results suggest that the local-level public health workforce in Iowa is very experienced. Table 3 indicates that 50% of respondents were college graduates. As shown in Table 4 respondents represent a wide variety of practice areas. The practice areas of health administration and policy, public health nursing, environmental health, community health consultant, and health officer account for almost 75% of responses.

**Table 1—Place of Employment**

<u>Agency</u>	<u>Percentage of Respondents (n=337)</u>
Local Public Health Department	34.7
State Public Health Department	29.1
University/College	9.2
Non-profit organization	7.7
Community Health Center	5.9
Hospital or other health care facility	4.5
Public Health Nursing Agency	3.9
Environmental Health Department	2.4
Home Care Agency	2.4
Laboratory	0.3

**Table 2—Years with Current Employer**

<u>Years at Agency</u>	<u>Percentage of Respondents (n=359)</u>
Less than 1 year	8.1
1 - 3 years	27.6
4 - 6 years	14.8
7 - 10 years	9.7
10 or more years	39.8

**Table 3—Educational Attainment**

<u>Educational Attainment</u>	<u>Percentage of Respondents (n=359)</u>
High school graduate	3.9
Some college	10.0
College graduate	50.7
Master of Public Health	8.9
Other Masters	22.0
PhD, MD or other doctoral level degree	4.5

**Table 4—Practice Area**

<b>Practice Area</b>	<b>Percentage of Respondents (n=258)</b>
Health Administration and Policy	23.3
Public Health Nurse	19.0
Environmental Health	11.2
Community Health Consultant	10.9
Health Officer (Department Director)	10.5
Health Education	8.1
Health Planner	3.9
Epidemiology	2.7
Dietician	2.7
Student	2.3
Dentist/Hygienist	1.6
Board of Health member	1.6
Biostatistician	1.2
Laboratory Personnel	1.2

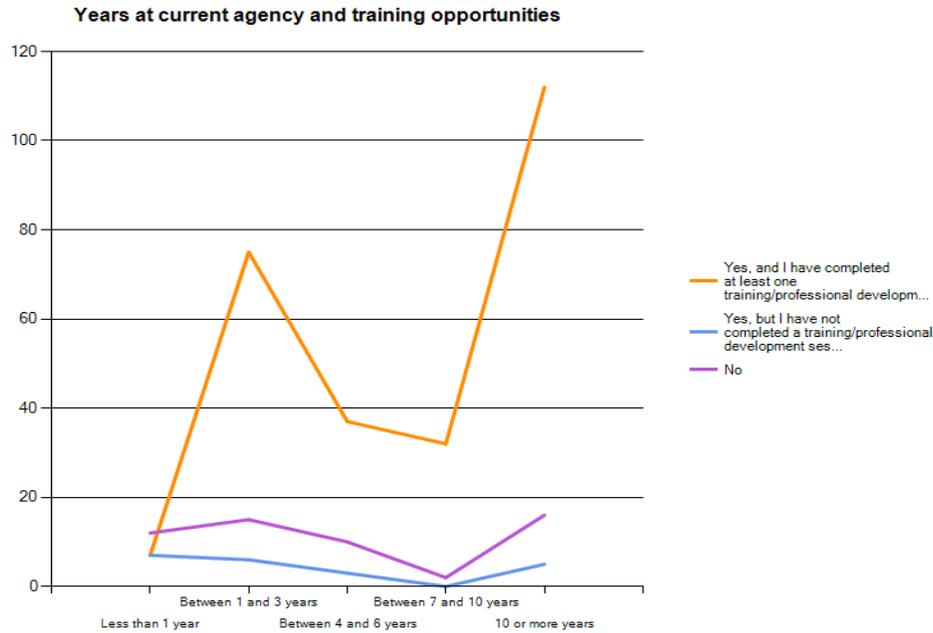
## **RESULTS**

### **TRAINING OPPORTUNITIES**

The main objective of the survey was to determine whether local public health practitioners currently or routinely seek training or continuing education opportunities in the area of cultural competence. Eighty-one percent (81%) of survey respondents have been *offered* the opportunity to participate in at least one training session since being hired at their current agency, 15.5% have not been offered a training opportunity, and 3.4% are uncertain. Seventy-five percent (75%) of survey respondents had completed at least one cultural competency training session.

Of the 287 respondents who reported being offered the opportunity to participate in a training session, 92.6% had completed at least one cultural competency training session and 7.3% had not completed a session. When asked to briefly explain why they had not participated in a training session, respondents frequently cited time, staff scheduling, location inconvenience, and illness (n=22).

When looking at the results by years at current agency, only 25% of respondents who had worked for their current employer for less than one year reported completing cultural competency training. However, as indicated in the graph on the following page, individuals who had a longer tenure at their current agency reported much higher rates of completing cultural competency training. These data suggest a need to incorporate cultural competency training in the orientation phase of public health positions and a need to make cultural competency training more easily accessible.



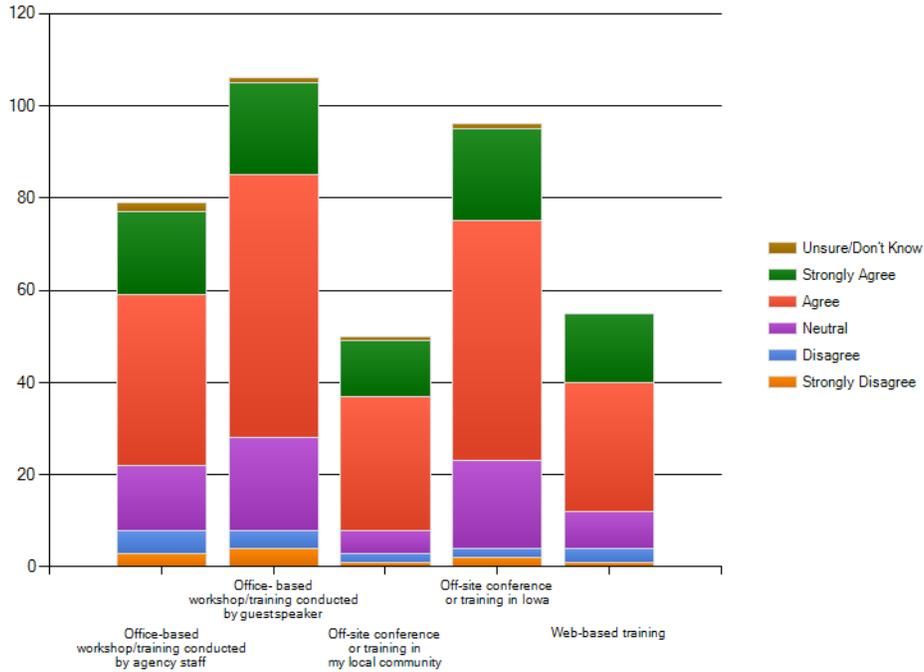
**TRAINING MODALITY**

Respondents were asked to indicate how the training(s) they had attended were delivered. As shown below, office-based training conducted by a guest speaker was mentioned most often, followed by off-site conference in the state of Iowa, and office-based training conducted by agency staff. Respondents who worked at the Iowa Department of Public Health, community health centers, non-profit organizations, and universities were more likely to report being trained by agency staff at their own office. University personnel also reported higher rates of completing web-based training.

<u>Training Modality</u>	<u>Number of Responses (select all that apply)</u>
Office-based workshop conducted by guest speaker	107
Off-site conference or training in Iowa	96
Office-based workshop conducted by agency staff	79
Web-based training	55
Off-site conference or training in my local community	51
Off-site conference or training outside of the state	31
Paper-based	23
Iowa Communications Network	10

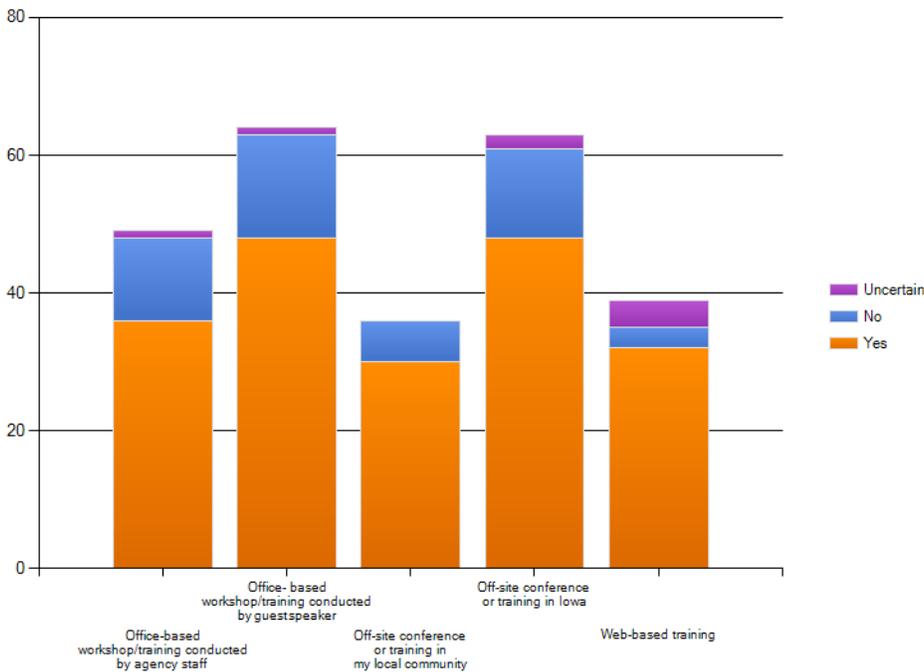
Project staff utilized the TAACT and Camphina-Bacote models to analyze the impact of the training modalities. When respondents were asked whether they had learned to “locate and utilize concepts, tools, and techniques” to improve health outcomes for diverse populations, respondents who had received training at off-site conferences in their local community had the highest rate of positive responses (82%), followed by web-based training (78.2%) and off-site training in Iowa (75%).

**Training Modality and Locating Cultural Competency Resources**

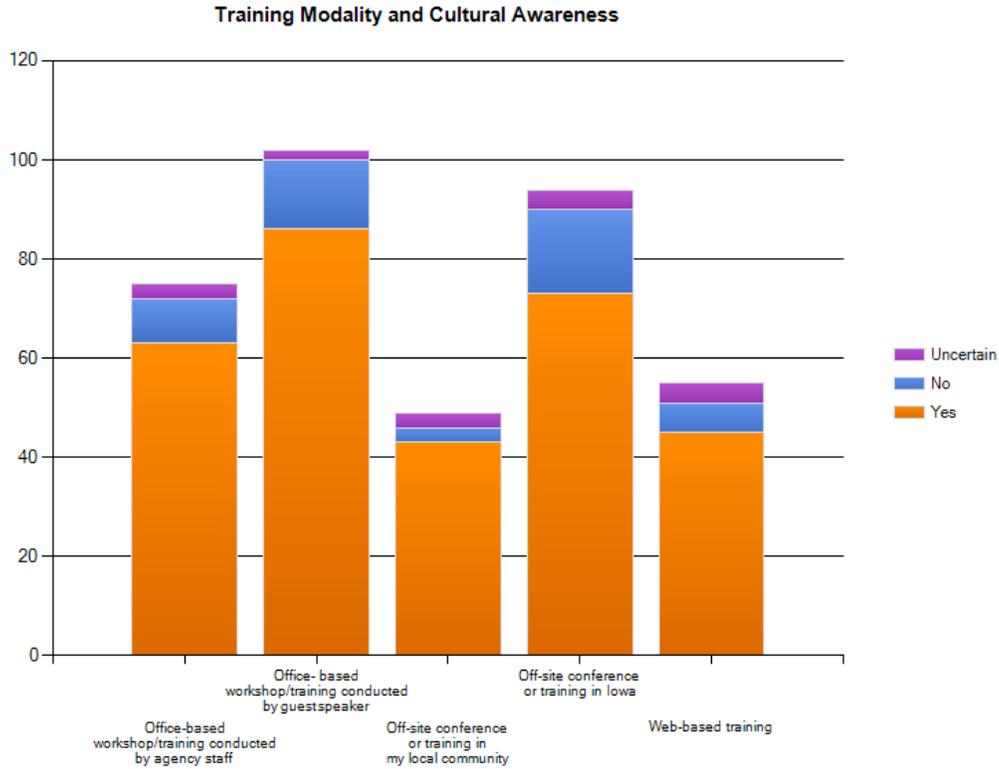


When asked whether they utilize the resources their agency “provides to improve the way I work with people from different backgrounds,” those who attended off-site training in their local community again reported the highest rate of positive responses (83.3%) followed by web-based training (82.1%).

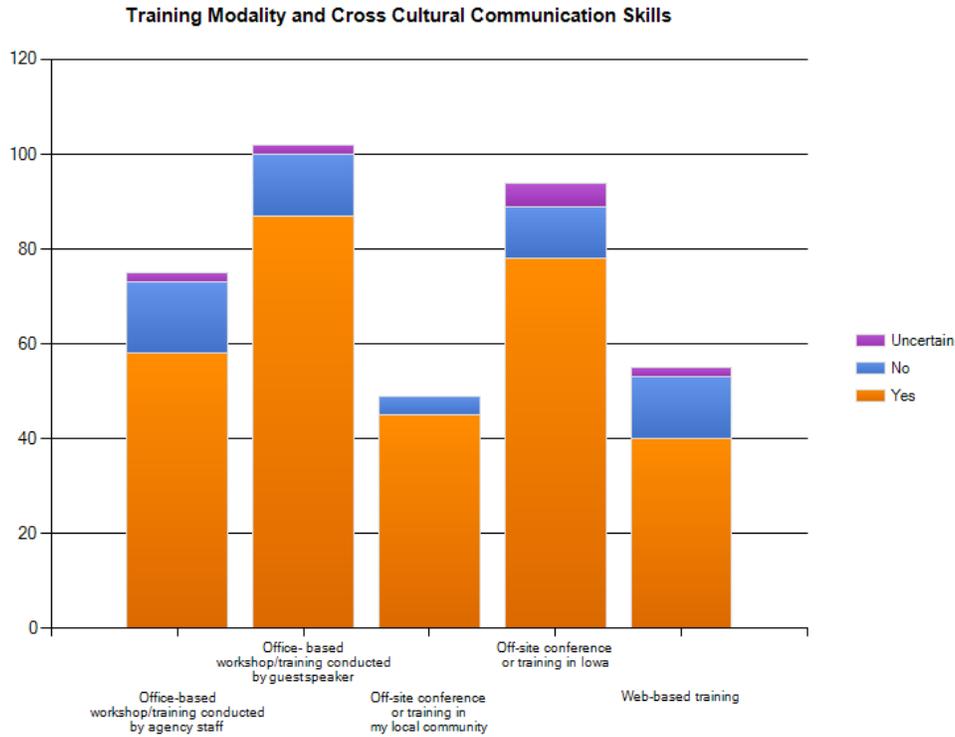
**Training Modality and Cultural Competency Resource Utilization**



When asked whether they have had the opportunity to evaluate their own cultural and ethnic beliefs and biases and how they may impact their work, respondents who had attended off-site trainings in their local community again reported the highest rate of positive responses (87.8%) followed by office-based trainings conducted by a guest speaker (84.3%).



When asked whether they have completed training on how to better communicate with people from diverse backgrounds, respondents who attended off-site training in their local community again reported the highest rate of “yes” responses at 91.8%, followed by office-based guest speakers.

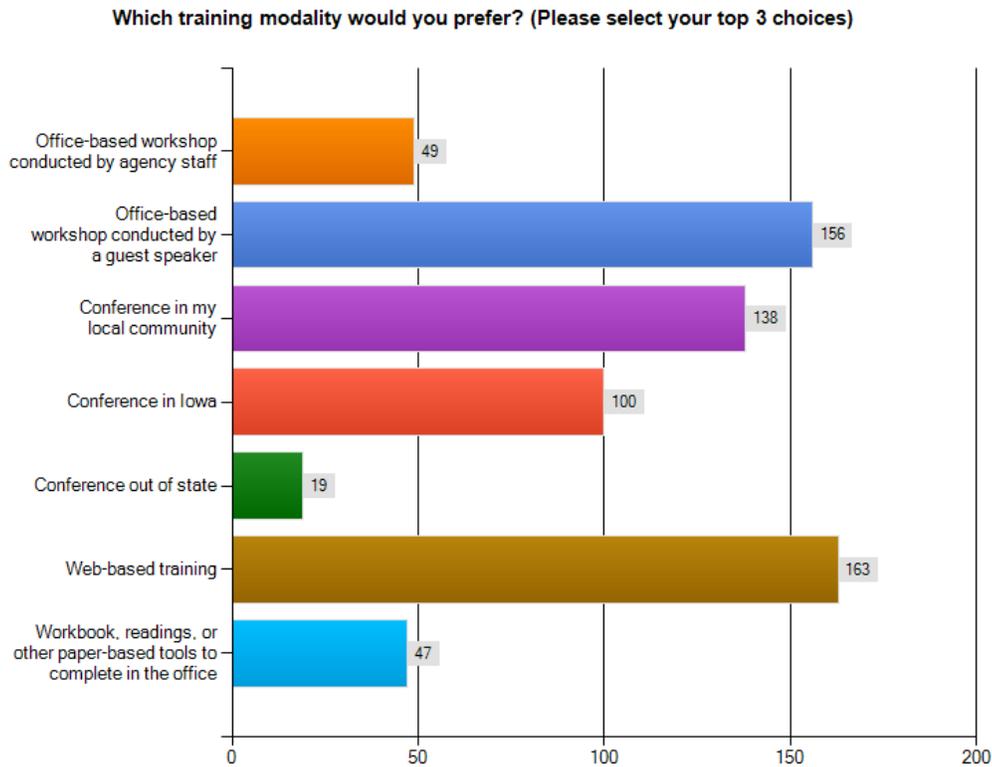


Respondents who attended off-site trainings in their local community were also more likely to report completing an assessment of their agency’s ability to serve people from diverse backgrounds. These findings indicate that off-site trainings or conferences held in local communities may be more effective in delivering information and skills regarding cultural competency resources, cultural awareness, and cross-cultural communication skills than other common training delivery modalities.

Respondents who attended off-site training in Iowa were more likely to be aware of the last time their agency assessed their progress in providing services to people from diverse backgrounds (27.1%). Respondents who attended office-based training by agency staff (37.8%) and those who completed web-based trainings (38.9%) were more likely to report that they had assessed their own ability to communicate with and serve people from diverse backgrounds.

## PREFERRED TRAINING MODALITY

When asked about the type of training/professional development in which they would prefer to enroll, most respondents chose web-based training (163), followed by office-based workshop using a guest speaker (156), conference in local community (138), and conference in Iowa (100).



Respondents who had received office training by agency staff, attended a conference in Iowa, and completed web-based training all preferred to complete web-based cultural competency training in the future. Respondents who had completed training at a local conference preferred that modality and respondents who had completed training by a guest speaker at their own office preferred that modality.

## TRAINING CONTENT

Another objective of this survey was to determine whether there are any gaps in the content or quality of the training resources currently being utilized by public health practitioners. While 75.1% of respondents reported receiving cultural competency training, it is important to assess whether these trainings covered the important competencies identified by the TACCT and Campina-Bacote models. In order to measure existing trainings' emphasis on *cultural awareness*, respondents were asked whether "as part of an in-service or other training/professional development event, I have had the opportunity to evaluate my own cultural and ethnic beliefs, the potential biases I may have, and how these may impact me and my work: 66.2% answered yes, 27.9% answered no, and 5.9% were uncertain. While respondents who had completed cultural competency training were much more likely to respond positively to this question (78%), 17.3% of respondents who had attended training answered "no." This suggests

that some existing training curricula may not adequately or effectively focus on cultural awareness. As a result, public health practitioners may not reflect on their own culture or be aware of how their own biases, prejudices, and assumptions may affect their work. Local department of public health respondents reported lower rates of evaluating their own cultural and ethnic beliefs (59.6%), while state health department (76.5%) and community health center (80.5%) respondents reported higher than average rates.

In order to measure existing trainings' emphasis on cross-cultural communication skill development, respondents were asked whether they had "completed a training/professional development session about how to better communicate with people who have a different background than I do" 64.1% of respondents answered "yes", 32% answered "no", and 3.9% were uncertain. While respondents who had attended cultural competency training were more likely to report they had received training on cross-cultural communication, 19.6% of respondents who had attended cultural competency training reported they had never been instructed on cross-cultural communication skills. These data suggest that cross-cultural communication skills are not included or adequately emphasized in many existing cultural competency trainings. State department of health (70.6%) and community health center (70%) employees were again more likely to report receiving instruction on cross-cultural communication while local department of health workers were less likely to report receiving this instruction (57.9%).

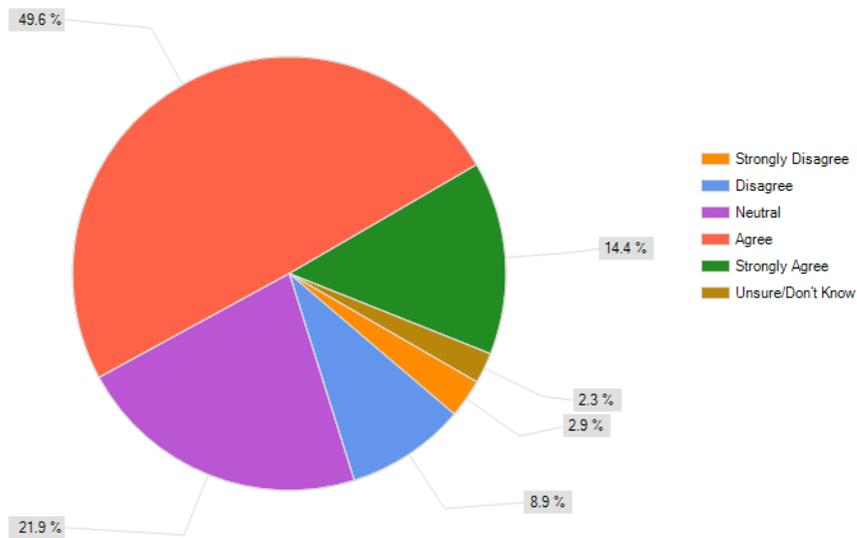
These findings suggest that state and community health center employees may be receiving higher quality, more frequent, or more memorable training on cultural awareness and communication compared with local department of health employees. However, neither of these findings related to trends in training delivery modality, educational attainment, or current practice area. Respondents who answered "yes" to all three questions (i.e. had completed cultural competency training, evaluated own culture and beliefs and been instructed on cross-cultural communication) were more likely to report they could locate cultural competency-related tools, that their agency provides resources to help them serve people from diverse backgrounds, and that their agency encourages them to be aware of their own culture and potential biases. These findings suggest some agencies may have a culture that is more focused on developing cultural competencies and serving diverse clientele.

Another important component of cultural competency is *cultural knowledge*, or obtaining information about diverse cultural and ethnic groups. The survey also assessed whether public health practitioners have access to, utilize, and benefit from books, videos, websites, and other resources to enhance their understanding of the clients they serve. Respondents were asked whether they had "learned to locate and utilize concepts, tools, and techniques to create improved health outcomes for people from different cultures and backgrounds" 64% agree or strongly agree, 21.9% were neutral, 11.8% disagree or strongly disagree and 2.3% were unsure. Respondents who reported they had completed at least one cultural competency training were far more likely to agree or strongly agree with this statement (70.3%), compared to those who had not completed training (57.1%) and those who had not been offered the opportunity to attend a training (37.0%). These data suggest that the trainings currently accessed and completed by public health practitioners in Iowa have been successful at emphasizing the importance of seeking an educational foundation about diverse ethnic groups and helping practitioners access

the resources they need to work with diverse clients. Local department of public health employees (64%) were more likely than state department of public health employees (57%) to report they had learned how to locate cultural competency resources.

In reviewing the data by the number of years the respondent had worked at their current agency results indicate that public health practitioners learn more about how to locate and use resources and tools to improve health outcomes for diverse populations during the course of their career 39% (less than one year) to 40% (4-6 years) to 57% (10 or more years). Therefore, it may be more effective to introduce these resources and incorporate these skills during orientation.

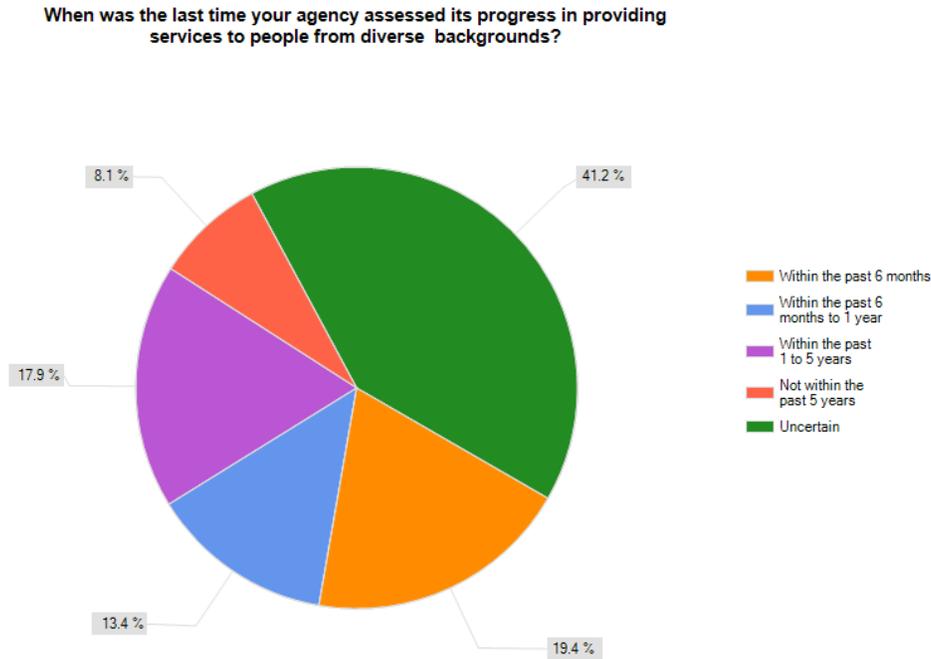
I have learned how to locate and utilize different concepts, tools, and techniques to create improved health outcomes for people from different cultures and backgrounds.



### PUBLIC HEALTH AGENCIES

In addition to collecting information on current training access, modality, and content, the survey also included questions to gauge whether public health employment sites across the state encourage their employees to develop cultural competencies and evaluate their ability to serve diverse clientele. When asked to indicate the last time their agency “assessed its progress in providing services to people from diverse cultural, ethnic, and linguistic backgrounds,” 19.4% of respondents chose “within the past 6 months,” 13.4% chose “within the past 6 months to 1 year,” 17.9% chose within the past 1 to 5 years, and 8.1% chose “not within the past 5 years.” However, the largest proportion of respondents, 41.2%, indicated they were “uncertain” when their agency last assessed its progress serving diverse clientele. The data suggest that many local public health employment sites do not assess their ability to work with diverse clients, do not involve their employees in this assessment process, or do not disseminate the results of these assessments to their coworkers. However, respondents who reported they had completed at least one cultural competency training session were less likely to report being “uncertain” (35.3%),

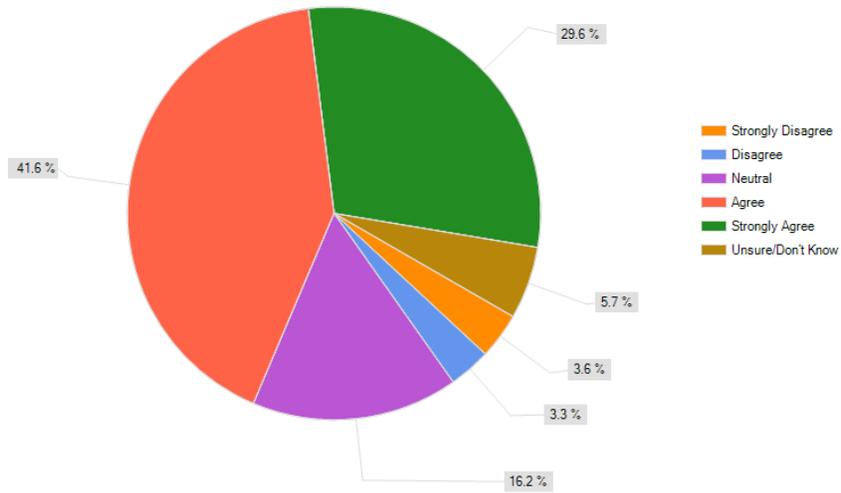
indicating that the agencies they work for conduct more frequent assessments or that they are more aware of or involved in the assessment process.



Respondents were also asked whether they feel their agency’s “vision statement, mission statement, and policies and procedures reflect a commitment to serving clients of different cultural backgrounds.” As shown on the following page, 71% of respondents either agreed or strongly agreed with this statement. University, non-profit organization, community health center and state department of public health employees reported higher rates of positive responses.

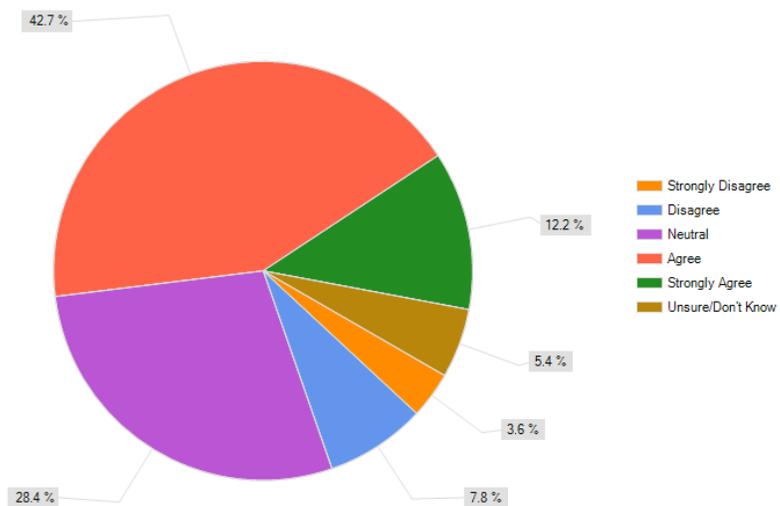
Additionally, respondents who had not been offered the opportunity to participate in a cultural competency training session at their current agency were more likely to be “neutral” and to indicate that their agency’s policies do not reflect a commitment to working with people from diverse backgrounds. This result suggests that agencies may have internal cultures that impact whether they are supportive of their staff developing cultural competencies and whether they consider adapting their programs for diverse clientele to be a priority.

**Agency Commitment to Serving Diverse Clients**

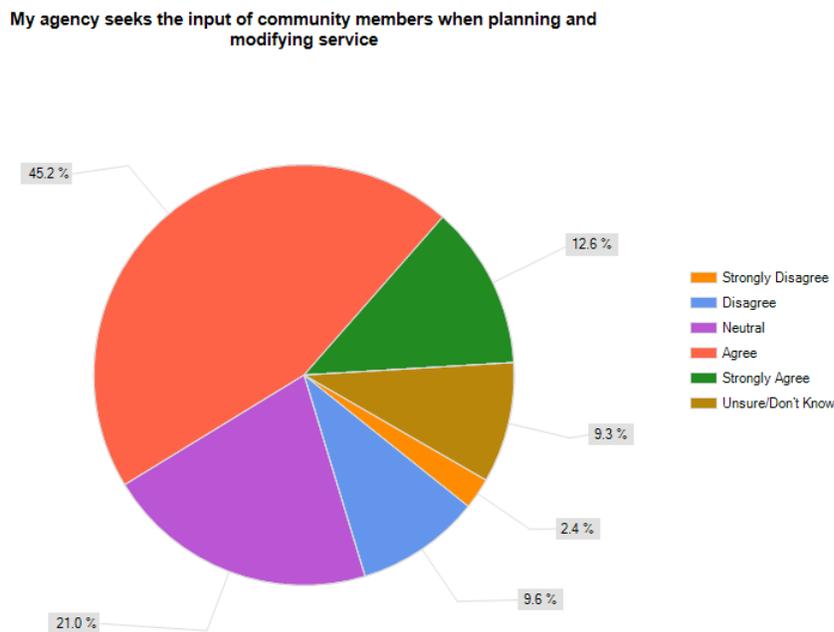


Respondents were also asked to indicate whether their agency “encourages staff to become aware of their own culture and to develop their own appreciation of diversity.” As shown below, 55% of respondents agreed or strongly agreed with this statement. Respondents who had been offered the opportunity to attend at least one cultural competency training session were more likely to respond positively to this question (66%), again suggesting that agencies may have their own culture that impacts whether staff are encouraged to attend cultural competency trainings and whether they are encouraged to be aware of and consider their own culture and possible biases.

**My agency encourages staff to become aware of their own culture**



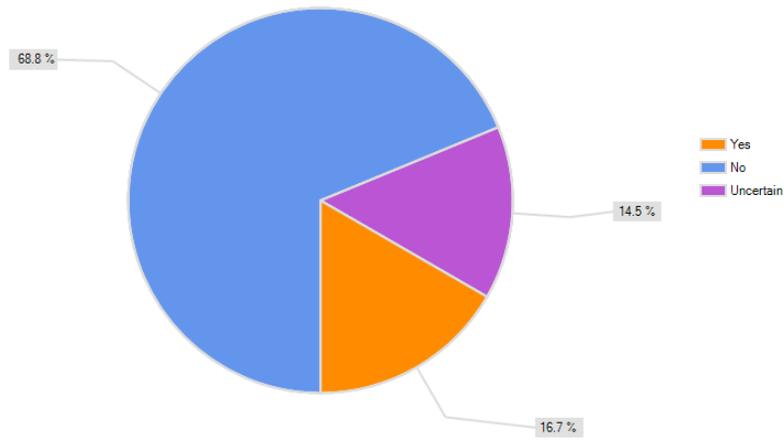
Respondents were also asked whether their agency “seeks the input of community members and considers the cultural implications of their decisions” when developing new programs or modifying their services. As shown in the graph below 58% of respondents agreed or strongly agreed with this statement although 42% of respondents gave negative or neutral answers. These findings suggest that agencies may not seek or consider the input of community members when developing and modifying new programs and services. Respondents who had been offered the opportunity to attend (60.7%) or had completed at least one cultural competency training session (72.3%) were far more likely to agree or strongly agree that their agency seeks community input than those who had not been offered a training session (40.3%).



### **ORGANIZATIONAL- AND SELF-ASSESSMENT**

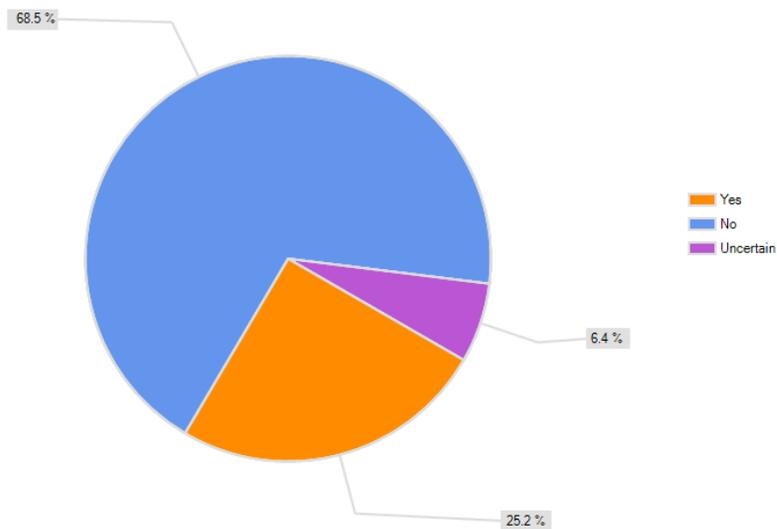
One component of some cultural competency training curricula is organizational- and self-assessment. Respondents were asked if they had ever completed an assessment of their “agency’s ability to communicate with and serve people from diverse linguistic and cultural backgrounds.” Only 16.7% of respondents answered “yes”, while 68.8% answer “no” and 14.5% were uncertain. Respondents who had completed at least one cultural competency training were only slightly more likely to report they had completed an organizational assessment (17.5%). These data suggest that the majority of trainings currently accessed by public health practitioners do not include an organizational assessment or that survey respondents do not recognize them as such. Additionally, these results suggest that public health organizations may not be involving staff in the implementation and analysis of their organization’s cultural competency assessments.

I have completed an assessment of my agency's ability to serve clients from diverse backgrounds



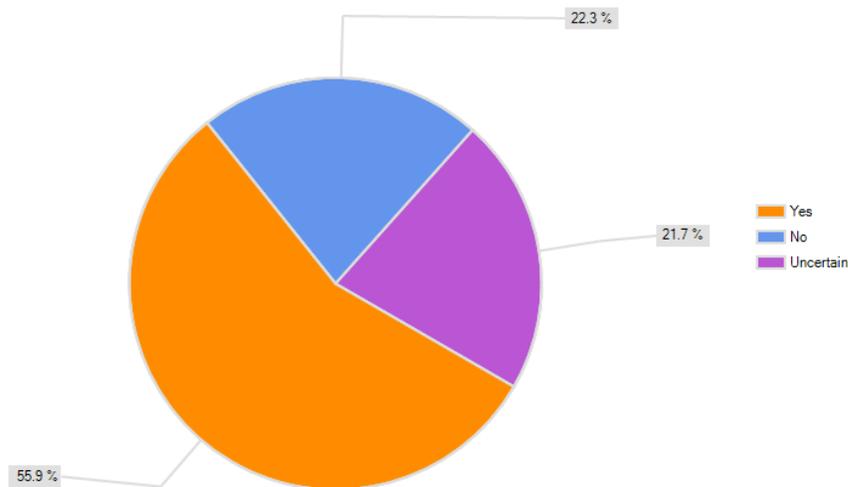
Respondents were asked to indicate whether they had ever completed an “assessment of their personal ability to communicate with and serve people from diverse linguistic and cultural backgrounds:” only 25.5% answered yes, 68.5% answered no, and 6.4% were uncertain. While this is slightly higher than the rate for organizational-assessments, respondents who have completed at least one cultural competency training were again only slightly more likely to report completing a self-assessment than those who had not attended or been offered a training opportunity. These data suggest that most existing trainings do not include a self-evaluation component and that public health agencies and individuals do not complete these assessments on their own.

I have completed an assessment of your personal ability to serve clients from a diverse background.



Respondents were also asked whether their agency has “books, videos, and/or a list of websites and other resources that staff can use to enhance our knowledge and understanding of the cultures of the people they serve” 55.9% of respondents replied yes, 22.3% answered no, and 21.7% were uncertain. Of those who replied “yes,” 78.6% reported that they had utilized these resources. Respondents who reported they had not completed or been offered the opportunity to attend a cultural competency training were more likely to report they had used these resources at their current position (100% and 80%) than those who had completed at least one training session (77.8%). Respondents who replied “no” were asked to indicate whether they thought it would be helpful for their agency to provide such resources: 66.7% answered yes, 11.5% answered no, and 21.8% were uncertain. These data suggest that a cultural competency toolkit might be needed and desired by public health practitioners.

Our agency has books, videos, and/or a list of websites and other resources that staff can use to enhance our knowledge and understanding of the cultures of the people we serve.



### OPEN-ENDED QUESTIONS

The final two questions of this survey were open-ended, allowing respondents to share the obstacles and challenges they face in providing culturally competent public health initiatives and potential steps they could take to overcome them. The responses are summarized below. Appendix I includes additional information on the responses to the open-ended questions.

The first open-ended question asked respondents to list the three most important diversity related issues currently facing their agency. Overall, 195 respondents provided 500 answers to this question. The most frequently mentioned issues included:

- Barriers related to language, communication, and the need for interpreters/translators,
- Challenges related to diverse cultures and health beliefs
- Lack of diversity among staff members.
- Challenges incorporating cultural competencies and skills into work situations

The second question asked respondents to list three steps their agency could take to enhance its ability to communicate with and serve people from diverse backgrounds. In all, 170 respondents provided 400 answers. The most frequently mentioned steps included:

- accessing more cultural competency training and education
- increasing utilization of translators or interpreters
- developing partnerships with other agencies
- increasing community participation and input regarding programs and services

## **CONCLUSION**

Among survey respondents, 81% had been offered the opportunity to participate in a cultural competency training session and 75% had completed at least one session. The greatest number of respondents reported attending an office-based training conducted by a guest speaker, followed by an off-site training in Iowa and an office-based training conducted by agency staff. While few respondents had been offered an opportunity to complete a training session and declined, their reasons for doing so indicate a need to make cultural competency training more convenient and accessible as well as a need to emphasize the importance of cultural competency training to agency leadership.

Initial analysis of training modality effectiveness suggests that off-site training in the local community may be particularly effective at helping practitioners locate and utilize cultural competency tools and techniques, reflect on their own cultural and ethnic beliefs, and develop cross cultural communication skills. Survey respondents reported that, when enrolling in future cultural competency trainings, they would prefer to take classes via the internet, from office-based guest speakers, and at a conference in the local community or within Iowa. These responses likely reflect an interest in convenient, accessible trainings as well as a desire to learn from field experts rather than agency staff.

Survey results suggest there is room for improvement among existing cultural competency trainings related to their instruction of cultural awareness, cross-cultural communication skills, and cultural knowledge. While respondents who had completed cultural competency trainings reported higher rates of positive responses in all three of these areas, the results suggest that some existing trainings do not adequately or effectively address these competencies. However, survey results also suggest that the trainings currently accessed and completed by public health practitioners have been successful at emphasizing the importance of seeking an educational foundation about diverse ethnic groups and helping practitioners access the resources they need to work with diverse clients.

The survey results also suggest that the ‘culture’ within public health agencies may impact the leadership and staff’s approach to cultural competency training and their commitment to serving clientele from diverse backgrounds. Respondents who were employed at agencies that had not yet offered them the opportunity to participate in cultural competency training were less likely to report that a) their agency had recently assessed its progress in serving diverse clientele, b) their agency’s policies reflect a commitment to working with diverse communities, c) their agency encourages staff to become aware of their own culture, and d) their agency seeks the input of community members. The survey results also indicate organizational- and self-assessments are not typically completed. More than half of respondents have access to books,

videos, and other websites and resources at their agency to enhance their knowledge about the clients they serve. Respondents who have access to such resources report high rates of utilization, while respondents without such tools indicate that they believe these resources would be useful for their agency.

The survey allowed respondents to share the challenges they face and the solutions they envision to providing culturally competent public health care in their communities. Respondents overwhelmingly cited language as a significant challenge and the increased use of interpreters and translators as a solution. Respondents also expressed a desire to attend additional, convenient, and high quality training sessions on cultural competency and a desire to learn more about diverse cultures and the health related problems they face. Respondents expressed a desire to create partnerships and networks to improve their culture competency and an interest in involving community residents in the planning, implementation, and evaluation of their public health initiatives. Staff also expressed a desire to recruit and retain a more diverse public health workforce.

## **RECOMMENDATIONS**

- **Web-based cultural competency training**
  - Public health practitioners would like additional training in cultural competency trainings that are accessible, affordable, and focus on cross-cultural communication skills, cultural awareness and cultural knowledge
  - To supplement recommended trainings, the Iowa Center on Health Disparities might consider creating a short, web-based training with specific information on Iowa's prominent cultures
  - Guidelines on the frequency of training should be developed
  - Training should be completed during the orientation period for new employees
- **Leadership training**
  - Training tailored to agency leadership may help leaders recognize the importance of organizational- and individual employee-cultural competence and encourage them to ignite change in the field of public health
  - Training could also provide guidance to agency leaders on how to “reach out” to their communities through advisory groups, focus groups, and community needs assessments, etc.
    - Involving local cultural groups at all levels of public health initiatives is known to improve the engagement and participation rates by clients and create positive impacts on health outcomes.
  - Trainings could also serve as a forum to create desired partnerships and translator databases recommended by respondents
- **Address language barriers**
  - The survey results suggest a significant need for language resources across the state, including access to the Language Line, interpreters and translators
  - Create partnerships and/or a database to improve access to translators
  - Provide policy recommendations related to language barriers

**NEXT STEPS:**

- Disseminate recommendations of Environmental Scan via the Institute for Public Health Practice Public Health Toolkit
- Establish timeline and training guidelines to assist individuals and agencies to begin to be more consistent and deliberate in what is offered for public health practitioners
- Consider organizing/conducting training for agency leadership on cultural competence and community outreach
- Consider partnerships to address language challenges and workforce diversity
- Share this report with other State Departments, organizations and/or coalitions that may benefit from having this data. This may also result in more intentional partnerships across departments that can ultimately work to meet the needs within Iowa communities.

## APPENDIX I OPEN-ENDED QUESTIONS

### **List Three Steps Your Agency Could Take to Enhance its Ability to Communicate and Serve People from Diverse Backgrounds**

The most frequently mentioned step identified by respondents was for staff to access more training and education opportunities related to cultural competency. Overall, 40% of responses related to a desire to public health agency employees to access additional training, education, conferences and workshops on cultural competency. Some respondents identified specific cultural groups about which they desired more knowledge, including people living in poverty, people with mental and physical disabilities, religion, sexual orientation, elderly people, American Indians, Marshallese people, and cultural differences in parenting. Based on the responses to this question, many public health practitioners recognize that cultural competency includes not only racial and ethnic minority groups, but also cultures related to different age groups, sexual orientation, religion and other backgrounds. Respondents provided a range of suggestions on how to best deliver cultural competency training, including providing sessions at IPHA's Annual Conference, mandating training for new hires, conducting immersion training i.e. poverty simulations, inviting speakers from diverse backgrounds to conduct local trainings, providing trainings at grantee meetings, and networking with other agencies to provide trainings. Respondents also indicated some shortcomings in their existing trainings and explained that staff need improved education related to "recognizing the culturally diverse," developing "cultural sensitivity," "recognizing the needs of diverse populations," "communicating with the diverse populations," the "effects of racism," "increasing knowledge about local cultures," and "applying cultural competency to real work situations." (It is important to mention that this survey's focus on cultural competency training may have swayed some participants toward a training-related response.)

Approximately 31% of all responses related to language and the need for an interpreter or translator at public health agencies. Common desires included providing signage and health education materials in foreign languages and communicating with clients who use Spanish and American Sign Language. Some respondents expressed desire to access the "Language Line," while others hoped to discontinue its use in favor hiring staff with multiple language skills or funding existing staff to learn a new language. Approximately 56% of respondents who cited language as an important area for their agency to address expressed a desire to increase their access to and utilization of interpreters and translators. Respondents suggested that interpreters would be useful to translate important documents, establish contacts with diverse prospective clientele, and accompany public health workers to home visits and that they would be more qualified and reliable than the "Language Line." A significant number of respondents cited a need for an organized network or database that lists reliable translators and their contact information. Another, less common, response related to the diversity and language capabilities of agency staff. Approximately 25 responses expressed a desire to hire more employees from diverse backgrounds, particularly racial and ethnic minorities. Some respondents stated that their agencies' receive few job applicants from diverse individuals and that they struggle to retain these employees. Additional responses expressed a desire to hire more bilingual staff members.

Many respondents also expressed a desire to develop partnerships and networks with other agencies and increase community participation in the planning, implementation, and evaluation of public health initiatives. Respondents suggested conducting small-scale field tests for new programs, conducting focus groups and town hall-style meetings to learn about community needs, asking community representatives to review health education material for cultural appropriateness, and creating advisory committees that include representation from diverse groups. Other respondents suggested partnering with other local agencies and community groups, especially those with diverse membership, to improve cultural competency training and participation by diverse groups. Other respondents emphasized the need to publicize services through multiple communication channels in order to reach different population groups and the need to conduct outreach to underserved areas and communities. Other suggestions included enumerating population demographics, increasing funding, accessing additional cultural competency resources and best practices, coordinating with the Office of Multi-Cultural Health at the IDPH, and creating an organization action plan to establish goals and evaluate progress related to cultural competency.

### **List the Three Most Important Diversity-Related Issues Currently Facing Your Agency**

Respondents cited translating marketing and health communication material, communicating with patients, and accessing and funding interpreters as the most frequent challenges. The next most commonly cited challenges were related to diverse cultures and their beliefs about health care: changing demographics, the influx of new ethnic and immigrant groups into their community, non-western health care beliefs, alternative health practices, and understanding cultural norms.

- “Lack of knowledge of how to assess one’s own values and beliefs in relation to other cultures”
- “The lack of expectation that clients from different backgrounds will learn about the unique culture of the United States”
- “Trying to educate the public about cultural myths related to health screening and disease management”

Another issue cited by many respondents was a lack of diversity among staff members. Respondents stated that the staff at their agencies are primarily white, female, and “graying,” do not represent the population that they serve, cannot speak foreign languages and that their organization has difficulty recruiting and retaining a diverse workforce. Respondents also explained that, due to time, staffing, and funding issues, their agency has difficulty incorporating cultural competency in their everyday work setting, seeking the input of community members, attending cultural competency training, and recognizing their social and cultural differences from the clients they serve. Respondents also indicated that they face challenges “identifying important health issues in diverse communities,” collecting “feedback about the effectiveness of materials,” and “assessing client satisfaction.”

- “Our diversity director is an older white man”
- “Older long term staff [doesn’t] seem to perceive the need for training others”
- “Some staff tend to view diversity as a Latino only issue, needs to be wider based to encompass all [diversity] characteristics of people”

Another commonly cited issue was a lack of financial resources to support staff's cultural competency development. Respondents explained that they lack funds to "gather population specific data," "conduct focus group testing with diverse populations," "develop culturally specific strategies," and to "develop culturally appropriate material." Respondents suggest that more funding should be granted to the Office of Multi Cultural Health at IDPH or through a state network devoted to addressing the health needs of specific population groups. In general, respondents expressed frustration:

- "We have insufficient resources to be all things to all people all the time"
- "[There are] unrealistic expectations that staff will become experts in all the various backgrounds of clients"

When asked to identify the three most important diversity-related issues facing their agency, many respondents cited specific characteristics, including age, immigrants and illegal residents, sexual orientation, religion, race, rural residents, Amish, gender, people with mental health conditions, young parents, and drug and tobacco users. A number of respondents cited the "poverty culture" and the problems faced by poor, unemployed, and uninsured residents. Respondents also cited "working with and understanding mental health clients," "determining the needs of people with LGBT orientation," "making their clinics more male-friendly," the generation gap and an aging population, serving rural populations, and working with young, unwed mothers as significant challenges. Unique challenges included:

- "Spanish interpreter not willing to work with family planning/contraceptive topics"
- "Spanish population always late and miss appointments"
- "Female employees working with Mid Eastern males"
- "A cross dresser client having services in office"
- "Conflict between religious beliefs and sexual orientation"
- "Assisting the Amish community who are reluctant to receive immunizations"

Asking survey participants to indicate the three most important diversity related issues facing their agency also revealed some practitioners who have not yet learned that "culture" can include factors other than race and ethnicity:

- "We are in rural Iowa: we have extremely few issues with ethnic variations"
- "Our community has very little to no race diversity"
- "Understanding that Iowa isn't as diverse as all the trainings would leave one to believe"

**APPENDIX II**  
**COMPARISON OF DATA COLLECTED FROM ALL RESPONDENTS WITH LOCAL PUBLIC HEALTH DEPARTMENT AND STATE PUBLIC HEALTH DEPARTMENT RESPONDENTS**

All Respondents: n=363

Local Public Health Department: n=117

State Public Health Department: n=98

**Years at Agency**

<b>How many years have you worked at your current agency?</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Less than 1 year	5.2	9.3	8.1
1-3 years	21.7	30.9	27.6
4-6 years	12.2	15.5	14.8
7-10 years	12.2	11.3	9.7
10 or more years	48.7	33.0	39.8

<b>Practice Area at your current position</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Allied Health Professional	0	0	0
Biostatistician	0	4.2	1.2
Board of Health	1.9	1.4	1.6
Community Health Consultant	1.9	31.9	10.9
Dentist/Dental hygienist	1.0	1.4	1.6
Dietician	1.0	4.2	2.7
Environmental Health	11.7	12.5	11.2
Epidemiology	1.9	6.9	2.7
Health Administration and Policy	23.3	19.4	23.3
Health Education	1.0	6.9	8.1
Health Officer (e.g., Department Director)	14.6	0	10.5
Health Planner	7.8	2.8	3.9
Public Health Nurse	33.3	2.8	19.0
Laboratory Personnel	0	2.8	1.2
Student	1	2.8	2.3

<b>Educational Background</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
High school graduate	3.4	6.1	3.9
Some college	6.9	10.2	10.0
College graduate	64.7	37.8	50.7
Master of Public Health	6.9	17.3	8.9
Other Master	18.1	22.4	22.0
PhD, MD, or other professional degree	0	6.1	4.5

<b>At this agency, I have been offered the opportunity to participate in at least one training/professional development session about the various social, cultural, and/or ethnic issues that affect the health of the people served by my agency.</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Yes, and I have completed at least one training/professional development session	68.1	86.3	75.1
Yes, but I have not completed a training/professional development session	7.8	5.3	5.9
No	19.0	8.4	15.13.4
Uncertain	5.2	0	

<b>How was the training you attended delivered?</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Office-based workshop/training conducted by agency staff	14	36	79
Office-based workshop/training conducted by guest speaker	35	41	107
Off-site conference or training in my local community	16	10	51
Off-site conference or training in Iowa	36	22	96
Off-site conference or training outside of the state	8	7	31
Web-based training	8	12	55
Paper-based training including articles, workbooks, etc.	3	9	23
ICN – Iowa Communications Network	1	2	10

<b>Since beginning my position at this agency I have learned how to locate and utilize different concepts, tools, and techniques to create improved health outcomes for people from different cultures and backgrounds.</b>	<b>Local DPH</b>	<b>State DPH</b>	<b>All Respondents</b>
Strong disagree	.9	5.4	2.9
Disagree	6.9	10.8	8.9
Neutral	25.9	21.5	21.9
Agree	47.4	49.5	49.6
Strongly agree	17.2	8.6	14.4
Unsure/Don't know	1.7	4.3	2.3

<b>Our agency has books, videos, and/or a list of websites and other resources that staff can use to enhance our knowledge and understanding of the cultures of the people we serve.</b>	<b>Local DPH</b>	<b>State DPH</b>	<b>All Respondents</b>
Yes	53.9	52.2	55.9
No	32.2	12.0	22.3
Uncertain	13.9	35.9	21.7

<b>I have utilized the books, videos, websites or other resources that my agency provides to improve the way I work with people from different backgrounds</b>	<b>Local DPH</b>	<b>State DPH</b>	<b>All Respondents</b>
Yes	<b>80.6</b>	<b>66.7</b>	<b>78.6</b>
No	<b>16.1</b>	<b>25.0</b>	<b>17.7</b>
Uncertain	<b>3.2</b>	<b>8.3</b>	<b>3.6</b>

<b>Do you think that it would be helpful for your agency to provide books, videos, websites, or other resources to help you learn about the cultures of the people you serve?</b>	<b>Local DPH</b>	<b>State DPH</b>	<b>All Respondents</b>
Yes	<b>70.9</b>	<b>60.0</b>	<b>66.7</b>
No	<b>10.9</b>	<b>17.8</b>	<b>11.5</b>
Uncertain	<b>18.2</b>	<b>22.2</b>	<b>21.8</b>

<b>As part of an in-service or other training/professional development event, I have had the opportunity to evaluate my own cultural and ethnic beliefs, the potential biases I may have, and how these may impact me and my work.</b>	<b>Local DPH</b>	<b>State DPH</b>	<b>All Respondents</b>
Yes	<b>59.6</b>	<b>76.5</b>	<b>66.2</b>
No	<b>33.3</b>	<b>17.6</b>	<b>27.9</b>
Uncertain	<b>7.0</b>	<b>5.9</b>	<b>5.9</b>

<b>Since being hired at this agency, I have completed a training/professional development session about how to better communicate with people who have a different background than I do.</b>	<b>Local DPH</b>	<b>State DPH</b>	<b>All Respondents</b>
Yes	<b>57.9</b>	<b>70.6</b>	<b>64.1</b>
No	<b>37.7</b>	<b>27.1</b>	<b>32.0</b>
Uncertain	<b>4.4</b>	<b>2.4</b>	<b>3.9</b>

<b>If you were to enroll in a training/professional development session on how to more effectively work with people from diverse backgrounds, which modality would you prefer?</b>	<b>Local DPH (n=112)</b>	<b>State DPH (n=84)</b>	<b>All Respondents (n=334)</b>
Office-based workshop/training conducted by agency staff	<b>10</b>	<b>20</b>	<b>49</b>
Office-based workshop/training conducted by guest speaker	<b>47</b>	<b>54</b>	<b>156</b>
Off-site conference or training in my local community	<b>46</b>	<b>24</b>	<b>138</b>
Off-site conference or training in Iowa	<b>39</b>	<b>18</b>	<b>100</b>
Off-site conference or training outside of the state	<b>3</b>	<b>5</b>	<b>19</b>
Web-based training	<b>60</b>	<b>36</b>	<b>163</b>
Paper-based training including articles, workbooks, etc.	<b>16</b>	<b>13</b>	<b>47</b>

<b>To the best of your knowledge, when was the last time your agency assessed its progress in providing services to people from diverse cultural, ethnic, and linguistic backgrounds?</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Within the past 6 months	15.8	20.2	19.4
Within the past 6 months to 1 year	8.8	13.1	13.4
Within the past 1 to 5 years	21.9	16.7	17.9
Not within the past 5 years	14	4.8	8.1
Uncertain	39.5	45.2	41.2

<b>My agency's vision statement, mission statement, and policies and procedures reflect a commitment to serving clients of different cultural backgrounds.</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Strong disagree	1.8	1.2	3.6
Disagree	5.3	2.4	3.3
Neutral	21.9	14.3	16.2
Agree	41.2	52.4	41.6
Strongly agree	21.9	23.8	29.6
Unsure/Don't know	7.9	6	5.7

<b>My agency encourages staff to become aware of their own culture and to develop their own appreciation of diversity.</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Strong disagree	1.8	2.4	3.6
Disagree	9.6	3.6	7.8
Neutral	28.9	29.8	28.4
Agree	50.0	46.4	42.7
Strongly agree	3.5	10.7	12.2
Unsure/Don't know	6.1	7.1	5.4

<b>When developing new programs or modifying services, my agency seeks the input of community members and considers the cultural implications of their decisions.</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Strong disagree	0	2.4	2.4
Disagree	10.5	10.8	9.6
Neutral	24.6	14.5	21.0
Agree	44.7	50.6	45.2
Strongly agree	12.3	10.8	12.6
Unsure/Don't know	7.9	10.8	9.3

<b>Have you ever completed an assessment of your agency's ability to communicate with and serve people from diverse linguistic and cultural backgrounds?</b>	<b>Local PHD</b>	<b>State PHD</b>	<b>All Respondents</b>
Yes	19.3	13.8	16.7
No	68.4	70	68.8
Uncertain	12.3	16.3	14.5

<b>Have you ever completed an assessment of your personal ability to communicate with and serve people from diverse linguistic and cultural backgrounds?</b>	<b>State PHD</b>	<b>Local PHD</b>	<b>All Respondents</b>
Yes	23.7	28.4	25.2
No	70.2	63.0	68.5
Uncertain	6.1	8.6	6.4

## **Appendix III**

### **LOCAL PUBLIC HEALTH DEPARTMENT RESPONDENTS**

#### **Respondents**

Of the 363 public health practitioners who responded to this survey, 117 reported that they currently work at a Local Public Health Department (city, county, or regional). Nearly half of these respondents have worked at their current agency for at least ten years, while only 26.9% had worked there for 3 years or less. Thirty-three percent of respondents reported that they are public health nurses, 23.3% work in “Health Administration and Policy,” 14.6% are Health Officers or Department Directors, and 11.7% report working in Environmental Health. A quarter of “local” respondents have a Masters degree and 64.7% are college graduates.

#### **Training**

When asked whether they have been offered the opportunity to participate at least one training “about the various social, cultural, and/or ethnic issues that affect the health of the people served by my agency,” 19% answered “No” and 75.8% answered “Yes.” Of those who had been offered this training opportunity, 89.7% had completed at least one session. When asked to indicate how the training(s) was delivered, 36 respondents reported that they had attended an off-site training in Iowa, 35 reported that they had attended an office-based training conducted by guest speaker, 16 reported that they had attended an off-site training in their local community, and 14 had attended an office-based workshop conducted by agency staff. Remarkably, only 8 respondents who are employed at local departments of public health reported that they had completed a web-based training. Nine respondents reported that they had chosen not to attend a training session and their common explanations were time, staffing, distance, illness, as well as training “not being a priority” in their county. When asked which modality they would prefer for future cultural competency training sessions, 60 respondents preferred web-based training, 47 preferred office-based training by a guest speaker, 46 preferred off-site training held within their local community, and 39 preferred off-site training in the state of Iowa.

#### **Training Content**

While 68.1% of local department of public health employees reported that they had completed a training session about the “social, cultural, and/or ethnic issues that affect the health of the people served by my agency,” fewer reported that they had received training in cultural awareness or cross-cultural communication. When asked whether they had had the opportunity to evaluate their personal cultural and how it may impact their work, only 60% of respondents answered “Yes.” Additionally, when asked whether they had completed a training session on how to better communicate with people from different backgrounds, only 57.9% answered “Yes.” This indicates that current trainings accessed by local department of public health employees may not include information on cross-cultural communication or cultural awareness. Additionally, only 23.7% of these respondents reported that they had ever completed an assessment of their personal ability to communicate with and serve people from diverse linguistic and cultural backgrounds, which indicates that assessments are not a standard part of current local department of public health training curricula.

### **Cultural Competency Resources**

Among respondents who work at local departments of public health, 64.6% reported that they had learned how to locate and use tools to improve health outcomes for people from diverse backgrounds. Fifty-four percent of respondents reported that their agency had resources that they could use to enhance their understanding of the cultures of the people they serve and, among these respondents, 80% reported utilizing these resources. Among respondents who did not have access, 70% believed that these resources would be useful for their agency.

### **Agency**

When asked about the last time their agency assessed its progress in providing services for people from diverse backgrounds, 54% reported that it was within the past five years and 40% were uncertain. Sixty-three percent of “local” respondents believe that their agency’s vision statement, mission statement, and policies and procedures reflect a commitment to serving clients of different cultural backgrounds, while 53.5% report that their agency encourages staff to become aware of their own culture. Fifty-seven percent report that their agency seeks the input of community members and considers the cultural implications of their decisions when developing new programs or modifying services. Only 19.3% of “local” respondents reported that they had ever completed an assessment of their agency’s ability to communicate with and serve people from diverse linguistic and cultural backgrounds.

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