Cultural Competency: How Is It Measured? Does It Make a Difference?

By Scott Miyake Geron

For agency administrators, service providers, and practitioners who work with older adults, the provision of culturally appropriate care increasingly has been recognized as essential to respond to growing diversity among older adults and in the workplace. The past decade has seen increasing awareness and support of education and service provision that promote "cultural competency" in healthcare (e.g., Julia, 1996; Kumabe, Nishida, and Hepworth, 1985; Kavanagh and Kennedy, 1992); in psychology, social work, and other professions (e.g., Padilla, 2001; Lum, 2003; Leigh, 1998; York, 1994; Hall, 1997; Boyle and Springer, 2001); and more recently in government and professional organizations (Meadows, 2000).

The difficulty in assessing the effectiveness of responses to diversity.

The reasons for the embrace of cultural competency are varied. A growing number of professionals working with older adults recognize the salience of understanding the cultural context in which any direct service takes place (Applewhite, 1998; Hall, 1997; Sue, Arredondo, and McDavis, 1992). Among psychologists, social workers, and other healthcare professionals, the movement to make professional education and services more culturally competent is seen as a professional opportunity and an imperative.

First, the movement presents an opportunity to begin to correct the incomplete and often inaccurate presentation of people of color and other historically underserved and undervalued populations that has heretofore characterized research, scholarship, and professional education. Second, it is imperative that these professions take into account the demographics of the older people and families they serve if they are to remain relevant (e.g., Pope-Davis et al., 1995; Sue, 2001; Hall, 1997; National Association of Social Workers, 2001). Indeed, advocates of cultural competency training and education argue that, without specialized training in multicultural counseling, agencies and professionals serving older adults of color are at best inadequately prepared to do their jobs (Boyle and Springer, 2001; Ponterotto, 1998; Suzuki, McRae, and Short, 2001) and at worst could be accused of violating the civil rights of their clients of color (Pope-Davis et al., 1995).

Particularly because of its growing importance, a number of measurement challenges in assessing cultural competency must be

addressed. How do we know whether "training" a care facility's staff about diversity actually improves the quality of care that is provided? How do we know when a clinical interaction is culturally competent? How valid are residents' perspectives on whether their nursing home environment is culturally responsive to their needs? This article outlines the difficulty in assessing the effectiveness of culturally competent responses to diversity and shows how much work remains to be done. Overall, while work in this area has helped to transform professional education and is making its mark on professional practice, it remains true that (1) better models and measures of cultural competence are needed in order to assess its effectiveness and utility, and (2) the influences of other worthwhile interventions may be seriously compromised and their measurement confounded by the lack of better measures of cultural competency.

The Importance of Measuring Cultural Competency

The basic challenge of measurement for any construct like cultural competency is to reliably and precisely capture its meaning in a way that is both practical and feasible. Why is it important to have an accurate measure of cultural competency? Perhaps the ultimate purpose is to help practitioners choose appropriate and effective interventions, to hold practitioners accountable for their professional behavior, and to hold organizations accountable for the services they provide. To achieve these basic purposes, we need psychometrically sound measures of cultural competency for tracking, assessment, and evaluation. An accurate assessment of cultural competency will allow agency administrators to more effectively monitor the capacity of their staff to provide culturally appropriate and responsive care, and to evaluate the effectiveness of cultural competency training and service provision.

That key question, whether and to what extent culturally competent service provision enhances the outcomes of services and treatment—perhaps the key argument and assumption underlying its expansion—certainly requires accurate assessments. Responses to issues raised on the impact among populations of race and ethnic disparities in health outcomes beyond those associated with poverty and poor education (see Johnson and Smith, this issue) mean that measures being developed to address this critical problem must be effective. The expected benefits of culturally appropriate care include improved outcomes in therapeutic interactions (Pope-Davis et al., 2002) and improved racial identity and therapy competencies (Neville et al., 1996). With improved measurement tools we can determine whether, by reducing dropout rates, poor attendance, and other factors, culturally competent care helps reduce racial and ethnic disparities in health outcomes (Brach and Fraser, 2000).

Basic Measurement Issues and Challenges

As interest in and support for the provision of culturally competent care grows, it is imperative that sufficient resources be devoted to studying what cultural competency means and how to measure it. Research is needed to address the following three related issues informing the assessment of cultural competency: (1) how best to understand and measure the perceptions of patients, clients, and care recipients of culturally appropriate care encounters and relationships with clinicians and other caregivers; (2) how best to understand, measure, and influence the attitudes and behaviors of practitioners, clinicians, and other care providers that most directly affect the perceptions that care recipients have of cultural competence; (3) how best to understand, measure, and assess the relative effectiveness of healthcare and social service organizations in encouraging more cultural competence in clinical and other service encounters.

Among the pressing measurement challenges that must be addressed if these goals are to be achieved are the following:

Uncertain definitions of cultural competency. Validity is perhaps the most important attribute of any measure because it refers to the extent to which an instrument measures what it is intended to measure and does not measure what it is not intended to measure. As described by others in this issue, definitions of cultural competency in the literature are now fairly common (Boyle and Springer, 2001). However, there

remain important differences in the definitions and there is no accepted conceptual framework for organizing the construct's multifaceted components. Even common definitions of cultural competency are difficult to operationalize, that is, put into terms that can be linked to identifiable, observable, or measurable behaviors or actions (Suzuki, McRae, and Short, 2001).

Cultural competency poses difficult measurement challenges in part because its meaning is so broad. Cultural competency is typically used in the context of clinical encounters or relationships between practitioner and client, physician and patient, health professional and service recipient. "Culturally competent" also has been used to describe organizations, and, in principle, the concept can be extended to apply to larger systems, such as cities, states, or even countries. With a different lens or focus on each level, can cultural competency mean the same in these different contexts?

Cultural competency sometimes is used in the context of just race or ethnicity, but the concept is also frequently used more broadly to include references to gender, sexual orientation, disability, and class (Suzuki, McRae, and Short, 2001). Can the same measure be applied to both a restricted and an expanded definition of cultural competency?

Perhaps the most widely used framework for understanding culturally competent counseling psychology is the model developed by Sue and colleagues (1992) that has formed the basis of most of the standardized measures of culturally competent care that have been developed to date. In their original formulation, three broad domains of cultural competency were distinguished—knowledge, beliefs and attitudes, and skill—and were later expanded, with specific areas of cultural competency identified (Sue, Arredondo, and McDavis, 1992).

Several of the most established measures of cultural competency are based on, or heavily influenced by, Sue's original model (e.g., see the Multicultural Counseling Inventory [Sodowsky et al., 1994]; the Cross Cultural Counseling Inventory, Revised [LaFromboise, Coleman, and Hernandez, 1991]; the Multicultural Counseling Awareness Scale, Form B [Ponterotto et al., 1993; Ponterotto et al., 1994]; and the Multicultural Awareness-Knowledge and Skills Scale [D'Andrea, Daniels, and Heck, 1991]). While these measures generally support the three-dimensional framework outlined by Sue (1982), Sodowsky and his colleagues (1994) have added a fourth dimension on multicultural counseling relationships. Sodowsky and colleagues and other analysts have argued for consideration of power, authority, authorization, and leadership dimensions (Suzuki, McRae, and Short, 2001).

Lack of client perspectives on cultural competency. Despite their increasing use in the field, the measures listed above have only begun to be subjected to key questions about practice and scientific utility. The measures remain limited in scope, relying almost entirely on self-report by practitioners or observations of clinical interviews. Perhaps the biggest weakness in these measures is that they are based on researcher-defined dimensions of cultural competency and do not include the client or care recipient's evaluation of the cultural competency of the care received. Thus, the accuracy of these assessments remains to some extent questionable and open to debate. Efforts to develop measures of services that take into account the views of consumers are crucial in this realm and are now being made in homecare and other areas of long-term care (e.g., see Geron, 2000; Geron et al., 2000).

The views of the consumer must also be considered in the area of cultural competency. It is inappropriate to base a judgment about a person's or provider's cultural competency without including input from the client or care recipient, arguably the person in the best position to make that judgment. There is no reason to expect clients, patients, or care recipients to evaluate the cross-cultural encounter in the same way as the professional care provider or the researchers who have studied cultural competency. Yet, at this time, little research has been conducted to learn whether clients experience interactions as culturally appropriate or inappropriate. One notable exception is a recent qualitative study by Pope-Davis and colleagues (2002) to examine client perspectives on cross-cultural clinical encounters.

Different definitions of organizational cultural competency. Very different definitions have been

developed for cultural competency within organizations. Organizational cultural competency addresses the capacity of an organization to support culturally appropriate and responsive care. Measures of organizational cultural competency focus much more on what are called structural or process measures that are familiar in healthcare and quality-assurance literature. These measures include a review of organizational mission statements for evidence of support of cultural diversity; outreach and hiring procedures that encourage engagement of people from historically undervalued and underserved groups; training in cultural competency for staff; policy and procedure manuals that support goals of diversity and cultural competency; specific hiring targets to increase diversity of the board, staff, or clients; and visible efforts within the organization to make the organization more welcoming to all cultural and linguistic groups (e.g., see Ducker and Tori, 2001). Most organizational cultural competency assessments include analysis of cross-cultural relationships between care providers and service recipients, but this component is usually only a small part of the overall assessments.

Currently there are a number of organizational assessments (sometimes called diversity audits) that have been developed to assess organizational cultural competency (Batts, 1990; Bluestone, Stokes, and Kuba, 1996; Education, 2001; Brach and Fraser, 2000). These organizational assessments generally have not been tested for their validity or reliability. The norm in this area is that organizations in the field of aging, including the American Society on Aging, use one or more of these assessments or have developed their own ad-hoc assessment tool.

One of the more widely used assessments is *The Assessment Handbook*, developed by Capitman and colleagues (1991). *The Assessment Handbook* examines organizational cultural competency in six key areas: mission; governance and organization; personnel practices and staffing patterns; service offerings and care-giving approaches; targeting and outreach; and marketing approaches. Exploring Differences in the Workplace (Mendez-Russel, Widerson, and Tolbert, 1994) is a measure used by organizations to assess their own cultural competency in four areas: knowledge (about stereotypes and basic information); understanding (awareness and empathy); acceptance (tolerance and empathy); behavior (self-awareness and interpersonal skills). In a recent example of a framework for assessing organizational cultural competency in health, Brach and Fraser (2000) list the following components of organizational cultural competency for health organizations: interpreter services; appropriate recruitment and retention; training; coordinating with traditional healers; use of community health workers; culturally competent health promotion; including family and community members; immersion into another culture; and administration and organizational accommodations.

While useful and increasingly popular, these types of assessments have a real problem in that they rely on easily observable indicators, such as the extent of board and staff diversity or written statements of support for diversity and cultural competency, rather than real evidence that culturally competent care is or is not being provided. Focusing on board membership, staff training, or written policies and procedures captures only the *possibility* that culturally appropriate and responsive care is provided. What is more, such an assessment can in some cases be easily manipulated because staff will know what they need to write in order to receive high cultural competency ratings. This approach to assessment is the one that has failed so spectacularly to ensure the quality of nursing home care. For example, we can well imagine mission statements or policy and procedure manuals that fail to be carried out in practice. While it is undoubtedly true that it is better for an agency to have, for example, written mission statements that support multiculturalism and diversity, the presence of such statements is not sufficient evidence that the agency is providing culturally competent care, just as the absence of such statements is not sufficient evidence that it is not. Cultural competency, just like the best healthcare and long-term care, is not entirely rule-driven.

Are we measuring what we want to measure? In many instances, a single question is all that is needed to measure a construct. For example, to learn a person's age, weight, or educational level, a single question on a survey is usually suffi-

cient. Cultural competency, however, is clearly a complex multidimensional concept that is impossible to define by a single item. Fortunately, most measures of cultural competency thus far have used multi-item measures. Multiple items increase the reliability of a measure's scores by "pooling" the information that items have in common and increase validity by providing a more representative sample of information about the concept. Multiple-item measures also provide the option, if item responses are missing, to estimate scores using other items in the measure, thus reducing missing scores on the multi-item scale.

As greater clarity emerges about the meaning of cultural competency, and new and revised measures of cultural competency are developed, an important next step is to ensure that an instrument for assessing cultural quality actually measures what it is intended to measure. For example, if an instrument were an accurate or valid measure of cultural competency, one would expect to see that an individual labeled "culturally competent" by use of the instrument would behave in ways that are consistent with our ideas of cultural competence.

Researchers use many different kinds of evidence to determine the validity of a measure and the appropriate interpretations of a score for a particular measure. The construct validity of a cultural competency measure will be established by examining the relationships between and among related measures and answering some basic questions: Can theoretical dimensions of cultural competency be confirmed empirically? What is the relationship between the dimensions of cultural competency? Are other accepted social science, psychological, and behavioral measures related to the dimensions of cultural competency in hypothesized ways? Are the measures biased? Do measures predict subsequent behavior or utilization of services in hypothesized ways?

Avoiding bias. Even when the validity of a measure has been well established, it is still imperative to avoid systematic errors, or bias, in responses, which could result in measuring something other than what we want to measure. There are a number of ways in which tests may be biased, particularly with older adults or when working with diverse language and cultural groups (Padilla, 2001). First, the content or construction of test items may be biased for some respondents in that the items lead to misleading answers or give unfair advantage to one group. A second type of bias has to do with how a measure is administered. For example, the formatting and model of administration of a measure (in-person, face-to-face, or by telephone) may inadvertently affect how one group of respondents answer questions. One example of this type of bias is a timed test, which may affect the scores of respondents who are not proficient in English. A third type of bias may occur through inappropriate recruitment or application procedures that can result in selecting one set of respondents over others.

In the first type of bias, the content of a test can be easily manipulated to favor one cultural or social group over another. Psychological testing and assessment is an area of professional practice that has been justifiably criticized for this reason (Padilla, 2001; Sue, Arrendondo, and McDavis, 1992). Poorly designed standardized tests have contributed to differential treatment of people from historically underserved and undervalued racial and ethnic groups and have thus contributed to perpetuation of social, economic, and political barriers. The major bias-related criticism is that tests have been developed with and standardized to apply to white, English-speaking Americans of European ancestry, making the reliability and validity of the tests open to question when the tests are used with people from different cultural or linguistic backgrounds. "Cultural blindness" in assessment occurs when test developers ignore culturally specific behaviors or areas that could influence responses to the test such as ethnic identity, formal education, English-language proficiency, and level of acculturation (Sue, 1998).

Another important example of this type of systematic bias is a tendency of respondents to provide incorrect or misleading answers to some types of questions, a type of bias that is potentially important for measures of cultural competency. "Socially desirable response" bias is the tendency to respond to questions with what is assumed to be the normatively "right" answer, or with the answer that the respondent assumes

the interviewer wants to hear. Such biased responses may occur because the purpose of measures of cultural competency may be obvious to participants in the study, increasing the chance that respondents will give socially desirable responses (Sodowsky et al., 1998). Obviously, the extent to which response bias operates in cultural competency assessments is an important area of study.

Is the measure reliable? Reliability refers to the consistency of a measure or to the extent to which the scores or results from a measure are free of random error. An example of a reliable measure is one that yields the same results on repeated administrations, provided the trait or construct being measured has not changed in the interim. To the extent that a result or score of a measure is unreliable, it becomes more difficult to observe or to measure a construct, and even an otherwise valid measure becomes useless if it cannot be reliably administered. The reliability of measures used is too often ignored, especially in development of new measures. Two important indicators of reliability should be calculated: first, the internal consistency of the items within dimensions and overall and, second, test-retest reliability of scores over time, by correlating scores for the same clients measured at two time points, usually no more than one week apart.

DISCUSSION

The above presentation highlights the most crucial aspects of research into the measurement and assessment of cultural competency. The rapidly growing diversity in our country has helped to focus new attention on the importance of developing culturally appropriate and effective care and of improving the training and education of professionals so that they can and will provide such care. An essential step toward this important goal is ensuring that we know what we mean by "cultural competency," that we use our understanding to determine ways to provide it, and that we develop and use means to measure whether it is in fact being provided and whether it is effective.

With few exceptions, existing efforts to measure the cultural competency of healthcare and social service providers have been developed ad-hoc and suffer from several shortcomings: (1) failure to define what cultural competence means; (2) failure to consider client and patient perspectives in the design of the measures; and (3) failure to test the reliability, validity, and psychometric properties of the measures. Let us hope that by the next issue of *Generations* on the topic of cultural competency, these problems will have been successfully addressed.

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