SINCLAIR SCHOOL OF NURSING

Report on the 2006 Missouri WIC Professional Staff Cultural Competency Survey

November, 2006

Teresa Curtis RD, MPH
Nutrition & Health Consultant-
Project Coordinator and Research Analyst
Constance Brooks, PhD., APRN, BC.
Principal Investigator
University of Missouri – Columbia
Sinclair School of Nursing

Acknowledgments

First and foremost, thank you to all of the WIC staff who participated in this survey. This feedback will enable Missouri WIC to develop tools, trainings, and seminars to assist you in your journey towards developing or maintaining cultural competence.

Thanks to Dr. Josepha Campinha-Bacote, President of Transcultural C.A.R.E Associates, for granting permission to use and adapt her tool.

The WIC Cultural Competency Training and Support Team at the Missouri Department of Health and Senior Services, WIC and Nutrition Services provided editorial review, comments, and guidance during this project. The Cultural Competency Team is:

Takako Tagami
Rita Arni
Brigette Henderson
Debbie Willhoit

Michael Murphy developed the database. Kelly Jacobs and Reba Brown entered the data.

This report was prepared by Teresa Curtis, Consultant to the University of Missouri-Columbia, Sinclair School of Nursing and reviewed and edited by Constance Brooks, Principal Investigator.

If you would like a copy of the report or have questions about the results, please contact Takako Tagami at one of the following:

Mailing Address:	Missouri Department of Health and Senior Services Division of Community and Public Health Section for Chronic Disease Prevention and Nutrition Services WIC and Nutrition Services 920 Wildwood Dr. Jefferson City, Missouri 65109
Phone:	(573) 751.6180
Fax:	(573) 526.1470
Email:	Takako.Tagami@dhss.mo.gov.

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Executive Summary

The purpose of the 2006 Missouri WIC Professional Staff Cultural Competency Survey was to assess the level of cultural competence among local Missouri WIC agency staff and identify areas for improvement. This information will be used to develop future cultural competence training and resource materials that will assist WIC agencies in providing more culturally appropriate services. Prior to this study, the cultural competence of Missouri WIC staff had not been assessed.

The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R), with a minor adaptation, was used (with permission of Dr. Campinha-Bacote) as the survey instrument for the 2006 Missouri WIC Professional Staff Cultural Competency Survey. The IAPCC-R was developed by Dr. Josepha Campinha-Bacote and is based on her model of cultural competence for health care providers ((Campinha-Bacote, 2003). The IAPCC-R consists of 25 items that measure her five interdependent cultural constructs of desire, awareness, knowledge, skill, and encounters, with five items addressing each of the five constructs (Campinha-Bacote, 2003, p.111). Although the IAPCC-R is designed to measure a person's overall level of cultural competence, information regarding the level of understanding for each cultural construct is useful in determining conceptual gaps. Therefore, data was analyzed to provide scores, or percent understanding, by construct as well as an aggregate score for cultural competence. Individual construct questions where 50% or more staff chose answers worth one or two points on the likert scale are discussed as areas in need of improvement.

Cultural desire: The average score for questions relating to cultural desire was 80.3%. The data did not show specific areas for improvement. Professional staff appear to be motivated to engage in cross-cultural experiences and develop the cultural awareness, knowledge, skills necessary to become culturally competent.

Cultural awareness: The average score for questions relating to cultural awareness was 66.1% Most professional staff indicated a limited understanding of "culture". Staff could also benefit from an improved understanding of systemic barriers to seeking healthcare services, such as a lack of a professional interpreter services or availability of translated documents.

Cultural knowledge: Cultural knowledge is the area in greatest need of improvement. The average score for questions relating to cultural knowledge was 49.7% Many staff are unfamiliar with the guiding principals, belief, and value systems of more than one cultural group. The majority of staff do not have a clear understanding of the potential differences in drug response attributable to a given ethnic group's genetic, environmental (such as dietary factors), structural and cultural variations in drug response). They are also lacking knowledge regarding differences in expression of phenotype and genotype; and are not cognizant of diseases that have a higher incidence and prevalence among certain ethnic and racial groups.

Cultural skill: The average score for questions relating to cultural skill was 61.5%. Staff are in need of increased awareness regarding the cultural limitations of existing assessment tools. Most staff could benefit from learning about the cultural assessment tools available. Collecting cultural information requires a certain level of comfort and many staff do not feel comfortable asking questions of people with different backgrounds. WIC staff have a very clear understanding of the relationship between culture and health. Although they are not familiar

with cultural assessment tools, staff do recognize the importance of performing cultural assessments with people from ethnically diverse families.

Cultural encounters: The average score for questions relating to cultural encounters was 67.3% Staff may benefit from having more multi-cultural experiences outside WIC; the majority of staff only interact with different cultural groups through work. Data shows that staff have a limited comprehension of intra-cultural variation. Many staff are aware of the need to improve their cultural competence skills and are seeking experiences to improve their effectiveness when working with different groups. Most staff indicated that they are able to maintain professional decorum and are not bothered by differences in values or beliefs.

Level of Cultural Competence: The aggregate mean score for staff was 65 points, which assess staff as "culturally aware". Based on the Campinha-Bacote scale, none of the staff are "culturally proficient"; 9.5% are "culturally competent"; most 89.8%) professional staff are "culturally aware"; and 0.7% are "culturally incompetent".

Recommendations

The following recommendations for the WIC program are based on survey data and analysis:

1) Develop "Cultural Competency 201": In order to improve their level of cultural competence, WIC staff need greater cultural awareness, improved cultural skills, more cultural encounters, and additional cultural knowledge. Most of these areas, except for cultural encounters, can be addressed through additional training. The training should build upon the information presented in "Cultural Competency 101" – i.e. "Cultural Competency 201". Since each WIC district serves a variety of different cultural groups, staff may learn more from a training that focuses on the cultural groups specific to their districts. Depending on the time and resources available, the training could address several or all of the topics common to every cultural group, as identified by Purnell (see section VI. Recommendations). If Missouri Department of Health and Senior Services (MO DHSS) were to develop a general training on specific cultural groups, the concept of intra-culture variation and a more inclusive definition of culture would have to be addressed.

2) Create a cultural competence training module for new staff: Cultural competence is not only an individual issue, but also an organizational issue. WIC agencies can promote cultural competence by developing a self-training or in-service module for all new and existing staff. Instituting a cultural competence training module communicates the importance of cultural competence to WIC staff while ensuring that all WIC families are treated with respect. The "Cultural Competency 101: Self-Assessment Checklist" created for the training binder would be a useful component.

I. Purpose of the Survey

The purpose of the 2006 Missouri WIC Professional Staff Cultural Competency Survey was to assess the level of cultural competence among local Missouri WIC agency staff and identify areas for improvement. This information will be used to develop future cultural competence training and resource materials in order to assist WIC agencies provide more culturally appropriate services. Prior to this study, the cultural competence of Missouri WIC staff had not been assessed.

II. Introduction

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is federally funded and administered by the United States Department of Agriculture (USDA). The Missouri WIC Program is administered by the Missouri Department of Health and Senior Services (MO DHSS), Division of Community and Public Health, Section for Chronic Disease Prevention and Nutrition Services. The Missouri WIC website states that the program provides health screening and risk assessment, nutrition education and counseling, breastfeeding promotion and support, referrals to services specific to individuals needs such as health care providers and social service agencies, and issues food instruments for supplemental nutritious foods prescriptions (MO DHSS, n.d.). These services are provided through local WIC providers, at no cost to eligible persons.

Between 1990 and 2004, the state of Missouri has seen an increase in the prevalence of every major racial and ethnic group, except for Caucasians (U.S. Census Bureau, 2000; Missouri Census Data Center, n.d.). In 1990 1.3% of Missouri's population could speak English less than "very well" (U.S. Census Bureau, 1990). By 2000 the proportion had grown to 7.5% (U.S. Census Bureau, 2000). Although there is no data on the level of English proficiency of WIC participants, local WIC agencies are surely affected by these shifts. As the population in Missouri continues to diversify, the skill set of WIC staff must also adapt to the State's changing cultural environment.

The United States Department of Health and Senior Services' Office of Minority Health believes cultural issues are the cornerstone for the appropriate delivery of health services, including treatment and preventive interventions. Culture is central to healthcare because it affects "…how health care information is received; how rights and protections are exercised; what is considered to be a health problem; how symptoms and concerns about the problem are expressed; who should provide treatment for the problem; and what type of treatment should be given" (Office of Minority Health, 2001). Therefore, a greater understanding of Missouri's cultural issues among WIC professional staff will improve the quality of care provided to WIC families. Advancement towards cultural competence will lead to an enhanced recognition of the cultural issues affecting health, and it will promote the provision of culturally responsive services.

Cultural competence is a complex integration of knowledge, attitudes, skills and experiences that enable an individual and an organization to *function effectively* within the context of the cultural beliefs, behaviors and needs presented by staff, consumers, and their communities

(U.S. Census Bureau, 2000; National Center for Cultural Competence, n.d.). By reflecting upon our own value system, the values and beliefs of others, adjusting stereotypes, gathering information, and interacting with others from diverse backgrounds, WIC staff will have a greater understanding of how to serve WIC families in the most culturally appropriate manner.

The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R), with a minor adaptation, was used as the survey instrument for the 2006 Missouri WIC Professional Staff Cultural Competency Survey (permission granted by Dr. Campinha=Bacote). The IAPCC-R was developed by Dr. Josepha Campinha-Bacote and is based on her model of cultural competence for health care providers. The model addresses five interdependent constructs: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters. Dr. Campinha-Bacote defines these concepts in the following terms:

- ***Cultural desire*:** The motivation of the healthcare professional to "want to" engage in the process of becoming culturally competent; not the "have to" (Campinha-Bacote, 2003, p. 15).
- ***Cultural awareness:*** The self-examination and in-depth exploration of one's own cultural background (Campinha-Bacote, 2003, p. 18).
- ***Cultural knowledge:*** The process of seeking and obtaining a sound educational base about culturally diverse groups (Campinha-Bacote, 2003, p. 27).
- ***Cultural skill:*** The ability to collect relevant cultural data regarding the client's presenting problem as well as accurately perform a culturally based, physical assessment (Campinha-Bacote, 2003, p. 35).
- ***Cultural encounters:*** The process which encourages the healthcare professional to directly engage in face-to-face interactions with clients from culturally diverse backgrounds (Campinha-Bacote, 2003, p. 48).

III. Methods

Survey Design

The Missouri WIC Professional Staff Cultural Competency Survey was adapted from the "Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals" (IAPCC-R). The adaptation was minor - the word "client" was replaced with "family". The IAPCC-R consists of 25 items that measure Dr. Campinha-Bacote's five interdependent cultural constructs of desire, awareness, knowledge, skill, and encounters, with five items addressing each of the five constructs. The items are measured using a 4-point likert scale. Scores indicate if the staff member is functioning at a level of "cultural proficiency" (91-100 points), "cultural competence" (75-90 points), "cultural awareness" (51-74 points), or "cultural incompetence" (25 – 50 points) (Campinha-Bacote, 2003, p. 111).

Data Collection

Missouri WIC Professional Staff Cultural Competency Surveys were given to WIC professional staff who attended one of the Cultural Competency 101 trainings given in the six

WIC district areas during July and September 2006: Jefferson City (Central); Macon (Northeast); Kansas City (Northwest); Poplar Bluff (Southeast); Springfield (Southwest); and St. Louis (Eastern). The self-administered surveys were distributed and collected before the training. Professional staff surveys were provided to administrators, WIC coordinators, nutrition coordinators, Competent Professional Authorities (CPAs), Health Professional Assistants (HPAs), WIC certifiers, breastfeeding coordinators, and breastfeeding peer counselors. In addition to their specific job titles, professional staff indicated their various credentials: Registered Dietitian (RD), nutritionist, Registered Nurse (RN), Licensed Practical Nurse (LPN), International Board Certified Lactation Consultant (IBCLC), and Certified Lactation Counselors (CLC).

Data Entry & Analysis

Double data entry was employed to reduce data entry errors. Data was entered into a Microsoft Access database that was converted into an SPSS® 12.0 for Windows file. All issues related to data entry were handled by WIC and Nutrition Services, including primary data cleansing. The consultant conducted a nominal descriptive analysis of the data using SPSS..

IV. Results

A total of 171 professional staff received the Missouri WIC Professional Staff Cultural Competency Survey, but only 147 surveys have been included in the analysis. Twenty participants did not answer all 25 questions and four participants circled more than one answer per question. It is impossible to know if the survey participants did not answer certain questions intentionally or if it was simple oversight. As for participants who provided more than one response per question, one cannot assume that participants were choosing an intermediate response. Therefore, the 24 surveys with missing or extra data were not included in the analysis. Data analysis is based on N = 147 participants.

Participation in the survey was almost evenly distributed across the districts, with Macon having about half of the number of participants of the other districts. WIC professional staff often have multiple job functions; 46.3% (n = 68) have more than one job. (For data on distribution of survey participation, job titles, and credentials, see Appendix A.)

Since registration for the Cultural Competency 101 training was voluntary, those who registered for the training may have chosen to participate in the training because of their interest in the topic. Thus, there may be a self-selection bias which renders the data non-generalizable to all Missouri WIC professional staff. Another limitation is that self-report tools, such as the IAPCC-R, may result in a self-report bias.

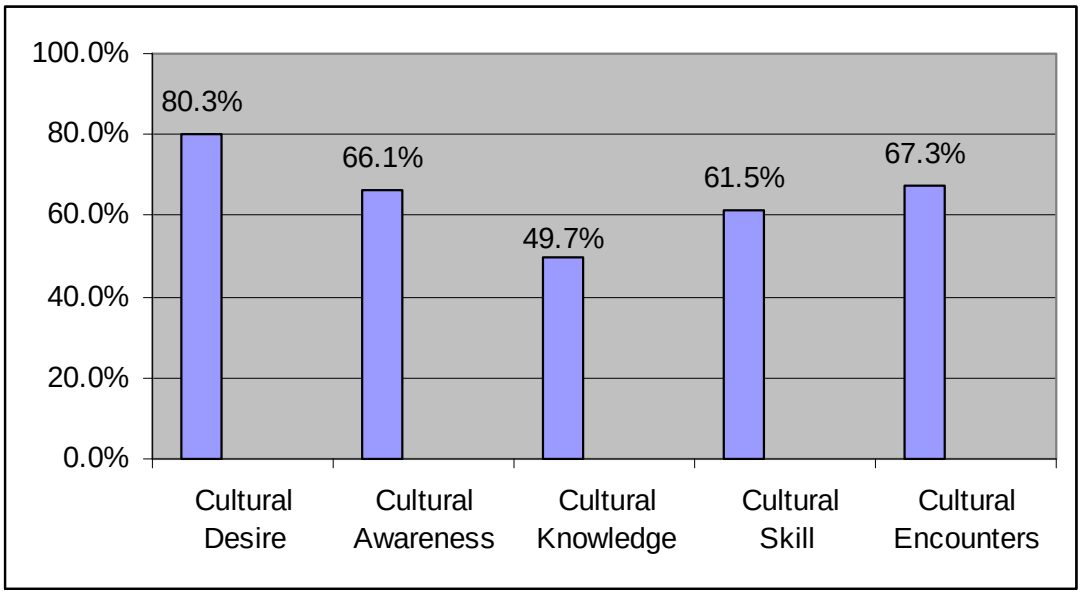
V. Findings & Discussion

Given their various job functions, many WIC professional staff interact with people from cultural backgrounds different from their own. These differences may be related to age, race, religious, socio-economic status, sexual orientation, physical limitations, etc. To ensure that WIC participants are receiving the best service possible, WIC professional staff must be able to provide services in a culturally appropriate manner.

Understanding the Five Cultural Constructs

The survey measures the participants understanding of the five constructs of cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. This section reports the professional staffs' score on the individual constructs (see Figure 1). Questions where 50% or more staff chose answers worth one or two points on the likert scale are discussed as areas in need of improvement. The cumulative score, reported in the next section, indicates their level of cultural competence.

Figure 1. Percent Understanding of the Five Cultural Constructs



Cultural desire

The average score for questions relating to cultural desire was 80.3% . The data did not show specific areas for improvement. Professional staff are motivated to engage in cross-cultural experiences and develop the cultural awareness, knowledge, skills necessary to become culturally competent.

Cultural awareness

The average score for questions relating to cultural awareness was 66.1%. Most professional staff indicated a narrow understanding of "culture". Culture refers to more than just a person's ethnicity or racial group. A person may define their culture by any number of characteristics including age, gender, socioeconomic status, religion, sexual preference, marital status, physical abilities, and physical limitations. Staff could also benefit from an improved understanding of systemic barriers to seeking healthcare services, such as interpreter services or translated documents.

Overall, professional staff scored well on topics relating to cultural awareness, however there is still room for improvement. Reflecting upon our backgrounds and beliefs, including positive and negative attributes, strengthens our ability to appreciate a different culture. WIC staff that are self-aware might also be more mindful of imposing their beliefs onto others (Campinha-

Bacote, 2003). Several self-assessment checklists are available, including the "Cultural Competency 101: Self-Assessment Checklist" created for the Cultural Competency 101 training binder.

Cultural knowledge

The average score for questions relating to cultural knowledge was 49.7%. The majority of staff are unfamiliar with the guiding principals, belief, and value systems of more than one cultural group. This type of cultural knowledge clarifies a family's perception of their situation and any action they may take (Campinha-Bacote, 2003). Although WIC staff are not directly involved with medical care, participants may share information with their WIC provider that they have not shared with their clinician, therefore it is important that professional staff be aware of what may be perceived as "clinical" cultural knowledge. Most staff are not clear about the potential differences in drug response attributable to a given ethnic group's genetic, environmental (such as dietary factors), structural and cultural variations in drug response; are lacking knowledge regarding differences in expression of phenotype and genotype; and are not cognizant of diseases that have a higher incidence and prevalence among certain ethnic groups.

Cultural knowledge is the area in greatest need of improvement. Textbooks and credible internet sites are excellent sources as information, as are international festivals, seminars, mission trips or other travel excursions. Staff could also look to the community for knowledge. Communicating with cultural leaders, such as religious figures or group leaders, is not only educational, but also valuable to establishing trust and credibility within the community. Gathering cultural knowledge requires a willingness to learn and break down stereotypes; learning to respect differences while building upon similarities. Working with families is not always about *giving* education; it is often about sharing information.

Cultural skill

The average score for questions relating to cultural skill was 61.5%. Many staff are in need of increased awareness regarding the cultural limitations of existing assessment tools. Assessment tools should include questions that will enable the health care staff to understand the beliefs, values and practices that affect how care is provided and received, such as the cultural beliefs and traditions regarding food or breastfeeding. Staff would benefit from learning about the cultural assessment tools available. Learning quick mnemonics, such as CONFHER, LEARN, and ETHNIC enables staff to collect valuable information in a minimum amount of time, without the burden of additional paperwork for the WIC family member (see Appendix B) (Fong, 1985; Berlin & Fowkes, 1982; Lefin, Like & Gottleib, 2000). Collecting cultural information requires a certain level of comfort and most staff do not feel comfortable asking questions of people with different backgrounds.

There are many different possible explanations for this discomfort. It could relate to the frequency with which staff encounter people from different backgrounds. If so, comfort levels will most likely increase proportionally to the diversity of the local agency's caseload. It could also be that staff are worried about unintentionally offending someone. While this is valid concern, people are generally able to discern the intention of a question. Questions asked with malice will offend, while those asked out of a desire to learn usually will not.

Assessment forms should also reflect the various cultures served by the local agency. Questions to consider when designing or updating forms may include: Is there enough space for multiple names?; Does the food frequency form include foods frequently eaten by people of the community?; Are forms translated into the correct dialect? Are documents translated literally, which may be poorly understood, or is the form a contextual translation which uses culturally relevant connotations and idioms?

WIC staff scored well on two cultural skill topics. WIC staff have a clear understanding of the relationship between culture and health. Although they are not familiar with cultural assessment tools, staff do recognize the importance of performing cultural assessments with people from ethnically diverse families.

Cultural encounters

The average score for questions relating to cultural encounters was 67.3%. Every cultural encounter is an opportunity to correct stereotypes and round out a person's perception of specific cultural groups. Staff may benefit from having more multi-cultural experiences outside of WIC; most staff only interact with different cultural groups through work. A person from a seemingly homogenous background or community may be intimidated by language barriers or a lack of understanding regarding cultural norms, but multi-cultural experiences are vital to developing cultural competence. Interacting with people from different backgrounds, during and after business hours, helps to develop a better understanding of various world views. Although slightly more than half of WIC staff indicated a comprehension of intra-cultural variation, many did not grasp this concept. It is important to remember that the values, beliefs and practices of a few people are usually not representation of the entire cultural group; there are more differences within a group than between groups (Campinha-Bacote, 2003).

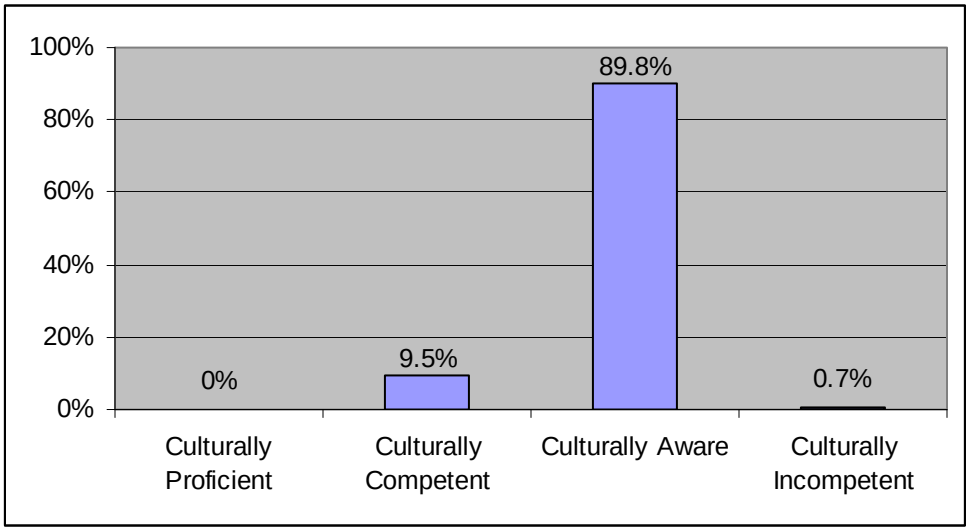
Data indicates that WIC staff are making an effort to have positive cultural encounters. Staff are aware of the need to improve their cultural competence skills and are seeking experiences to enhance their effectiveness when working with different groups. Most are able to maintain professional decorum and are not bothered by differences in values or beliefs.

The survey did not specifically address the use of interpreter services; however, many agencies anecdotally report using informal interpreters, such as family members. Agencies cite time and lack of resources, both human and financial, as reasons for not using on-site interpretation services, including bilingual staff, or over the phone interpretation services. Standard Four for Culturally and Linguistically Appropriate Services (CLAS - Appendix C) mandates the provision of interpreter services to persons with limited English proficiency at all points of contact.[6] The WIC State office may wish to further explore this issue.

Level of Cultural Competence

The aggregate mean score for staff was 65 points, which assess staff as "culturally aware". According to the Campinha-Bacote scale, none of the staff are "culturally proficient"; 9.5% are "culturally competent"; 89.8% professional staff are "culturally aware"; and 0.7% are "culturally incompetent" (Figure 2).

Figure 2. Percent Score by Level of Cultural Competence



According to the American Nurses Association, cultural awareness is " a deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs…of clients' cultures but it does not ensure they are providing interventions that are culturally responsive" (American Nurses Association, 1991). Although staff are not considered "culturally incompetent", based on their scores for the individual constructs it appears that a deeper understanding of cultural awareness, skill, and knowledge, could boost their level of cultural competence. Special emphasis should be placed on increasing cultural knowledge.

VI. Recommendations

Develop "Cultural Competency 201"

In order to improve their level of cultural competence, WIC staff need greater cultural awareness, improved cultural skills, more cultural encounters, and most importantly, additional cultural knowledge. Improving their level of cultural knowledge may have the added benefit of giving them the confidence necessary to have cross-cultural encounters after business ours. Most of these areas, except for cultural encounters, can be addressed through additional training. The training should build upon the information presented in "Cultural Competency 101" – i.e. "Cultural Competency 201".

Since each WIC district serves a variety of different cultural groups, staff may learn more from a training that focuses on the cultural groups specific to their districts. Inviting cultural leaders from local communities would provide both important information, and could also help to build or strengthen the relationship with the WIC program. Depending on the time and resources available, the training could address the following topics, or domains, which are common across all cultural groups (Purnell, 2002):

- Overview/heritage – country of origin and it's topography; current residence; economic issues; politics; reasons for migration; educational status; and occupations.
- Communication – dominant language and dialects, verbal and nonverbal communication, spatial issues, temporal orientation, names, and greeting etiquette.
- Family roles and organization - Head of the household and gender roles; roles of the aged and extended family members; family roles in general, priorities; and child-rearing practices.
- Workforce - autonomy, assimilation and acculturation, assimilation, and gender roles.
- Biocultural ecology – physical and biological differences, including issues of ethnopharmacology.
- High-risk behaviors - use of tobacco, alcohol, and recreational drugs; lack of physical activity; and high-risk sexual practices.
- Nutrition – access to food; the meaning of food; food choices, rituals, and taboos; food related to illness; and food related to wellness.
- Pregnancy and childbearing practices – fertility practices; methods for birth control; views toward pregnancy, birthing, and postpartum.
- Death rituals – individual and culture view death, rituals and behaviors to prepare for death, burial practices, and bereavement behaviors.
- Spirituality - religious practices and the use of prayer, behaviors that give meaning to life.
- Health care practice – the focus of health care (acute or preventive); traditional, magicoreligious, and biomedical beliefs; individual responsibility for health; self-medicating practices; chronicity; and barriers to health care.
- Health care practitioner - the status, use, and perceptions of traditional, magicoreligious, biomedical health care providers; and gender of the health care provider.

One of the deterrents to providing a general training on specific cultural groups is that it may give the impression that the information presented is true for all members, however, this is not the case. As discussed, staff did not demonstrate a thorough understanding of intra-culture variation. Another point to consider is the emphasis the training would place on culture and race. Scores indicated that staff do not take into consideration other cultural characteristics such as gender, occupation status, or education level etc, as characteristics that may define a persons' culture. If DHSS were to develop a general training on specific cultural groups both points would have to be addressed.

Create a Cultural Competence Training Module for New Staff

Cultural competence is not only an individual issue, but also an organizational issue. WIC agencies can promote cultural competence by developing a self-training or in-service module for all new and existing staff. Instituting a cultural competence training module communicates the importance of cultural competence to WIC staff while ensuring that all WIC families are treated with respect. The "Cultural Competency 101: Self-Assessment Checklist" created for the training binder would be a useful component.

VII. References

American Nurses Association. (1991). *Position Statement on Cultural Diversity in Nursing Practice.* Washington, DC: Author.

Berlin, E., and Fowkes, W. (1982). A Teaching Framework for Cross-cultural Health Care. *The Western Journal of Medicine*, 139 (6), 934-938.

Campinha-Bacote, J. (2003). Many faces: Addressing diversity in health care. *Online Journal of Issues in Nursing,* 8(1), Manuscript 2.

Campinha-Bacote, J. (2003). The process of cultural competence in the delivery of health care services: A culturally competent model of care. *Journal of Transcultural Nursing.* 13(3), 181 – 4.

Campinha-Bacote, J. (2003). *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care* (4th ed, pgs 111, 15, 18, 27, 35, 48). Cincinnati, OH, Transcultural C.A.R.E. Associates.

Fong, C. (1985). Ethnicity and Nursing Practice. *Topics in Clinical Nursing*, 7(3), 1-10.

Levin, S., Like, R., and Gottleib, J. (2000). ETHNIC: A Framework for Culturally Competent Clinical Practice. In Appendix: *Useful Clinical Interviewing Mnemonics. Patient Care,* 34(9): 188-189.

Missouri Census Data Center. Demographic Profile 3 Trend Report, 1990 – 2000. Retrieved on June 1, 2006 from: http://mcdc2.missouri.edu.

Missouri Department of Health and Senior Services. WIC: Special Supplemental Nutrition Program for Women, Infants and Children. Retrieved on October 5, 2006 from: http://www.dhss.mo.gov/wic/.

National Center for Cultural Competence. Curricula Enhancement Module Series: Glossary. Retrieved on April 3, 2006 from: http://www.nccccurricula.info/glossary.html.

Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), 2001. Retrieved on March 15, 2006 from: http://www.omhrc.gov/assets/pdf/checked/executive.pdf.

Purnell, L. (2002) The Purnell Model for Cultural Competence. *Journal of Transcultural Nursing.* Jul;13(3):193-6.

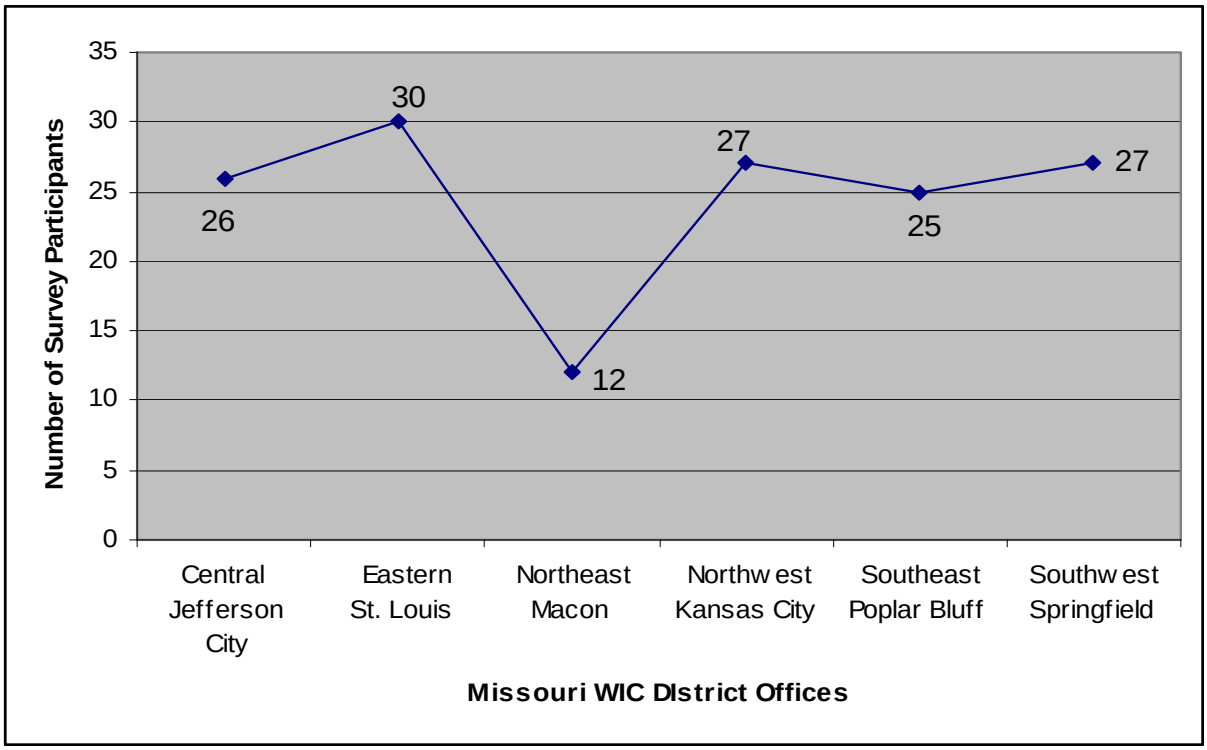
U.S. Census Bureau. U.S. Census 1990. Language Use & English Ability, Persons 18 years and over, by State. Retrieved on October 5, 2006 from: http://www.census.gov/population/socdemo/language/table3.txt

U.S. Census Bureau. U.S. Census 2000. Language Spoken at Home for the Citizen Population 18 years and Over Who Speak English Less Than "Very Well". Retrieved on October 5, 2006 from: http://www.census.gov/mp/www/spectab/languagespokenSTP194.xls

U.S. Census Bureau. U.S. Census 2000. Summary File 1 (SF 1) 100-Percent Data for Missouri. Retrieved on June 1, 2006 from: http://factfinder.census.gov/.

Appendix A: General Information - Distribution of Survey Participation, Job Titles, and Credentials

Number of Survey Participants by Missouri WIC District Offices



Primary Job Titles of Survey Participants

Title	%	Sample Size
Administrator	4.8	7
WIC Coordinator	21.8	32
Nutrition Coordinator	21.1	31
CPA	31.3	46
HPA	26.5	39
WIC Certifier	23.8	35
Breastfeeding Coordinator	19	28
Breastfeeding Peer Counselor	3.4	5

"Other" Job Titles of Survey Participants

Other Jobs	Sample Size
Administrative Assistant/Clerk/Clerical	16
BFC Coordinator	1
Interpreter	1
MCH Coordinator Diabetes	1
Nutrition WIC Supervisor/Area Supervisor	2
Outreach Coordinator	1
Special Project – State Office	1
Vendor Coordinator	2
WIC Technician	2
Total	27

Credentials of WIC Professional Staff

Credentials	%	Sample Size
Registered Dietitian (RD)	15.0	22
Nutritionist	23.8	35
Registered Nurse (RN)	16.3	24
Licensed Practical Nurse (LPN)	3.4	5
International Board Certified Lactation Consultant (IBCLC)	3.4	5
Certified Lactation Counselor (CLC)	5.4	8
Total	67.3	99

Appendix B: Mnemonic Cultural Assessment Tools

There are many mnemonic cultural assessment tools available. The mnemonics below are appropriate for the WIC setting. LISTEN and ETHNIC may be used for non cross-cultural communications. Staff can choose the areas most appropriate for their families.

CONFHER (Fong, 1985)
C: **communication style** – What is the preferred language and dialect? What are the verbal and nonverbal communication patterns
O: **orientation** –Which ethnicity or race or other cultural group do you (the patient) identify with? What are your values and ideas of acculturation and assimilation?
N: **nutrition** – Are there issues relating to food security? Explain the meaning of food; food choices, rituals, and taboos; food related to illness; and food related to wellness?
F: **family relationships** – How is family defined? How are decisions made? What impact, if any do head of household and gender roles; roles of the aged and extended family members; and family roles in general have in the decision making process?
H: **health beliefs** – What is the focus of health care - acute or preventive? What are their health beliefs - traditional, magicoreligious, or biomedical?
E: **education** – what is their learning style and level of educational. Have they had any informal education? What is their occupation?
R: **religion** – Are there religious practices? What are the behaviors that give meaning to life, and provide strength. Do their beliefs affect any of the services you will provide?

LISTEN (Berlin & Fowkes, 1982)
L: **listen** – to the patient's perspective
E: **explain** – your perspective
A: **acknowledge** – differences and similarities
R: **recommend** – treatment or plan of action
N: **negotiate** – agree on a treatment or plan of action

ETHNIC (Levin, Like & Gottleib, 2000)
E: **explanation** – how do you (the patient) explain your illness?
T: **treatment** – what treatments (traditional, herbal, pharmaceutical) have you tried?
H: **healers** – have you sough advice from traditional healers or other caregivers?
N: **negotiate** – mutually acceptable options
I: **intervention** – agree on a treatment or plan of action
C: **collaboration** – with individual, family, traditional healers or other caregivers.

Appendix C: National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The following information was retrieved directly from the website of the Office of Minority Health (http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3.) on March 15, 2006.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

- CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).
- CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1: Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2: Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3: Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4: Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive

language assistance services.

Standard 6: Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7: Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8: Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9: Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10: Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11: Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12: Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13: Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14: Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.