SINCLAIR SCHOOL OF NURSING

# Report on the 2007 Missouri WIC Staff Cultural Competency Survey

**September, 2007**


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# Acknowledgments

Many thanks to the local WIC staff who participated in the trainings and completed the survey. Your feedback will enable the Missouri WIC program to create resources that will help you provide the most culturally responsive services to Missouri mothers, caregivers, and their children.

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

Michael Murphy developed the database and cleansed the data. Reba Brown, Katie Hollis, and Bridgette Buschjost entered the data.

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# TABLE OF CONTENTS

# Executive Summary

The purpose of the 2007 Missouri WIC Professional Staff Cultural Competency Survey was to determine whether or not there have been improvements in the level of cultural competence among local Missouri WIC agency staff during three survey periods: Cultural Competency 101 in 2006, as well as the pre-tests and post-tests given during Cultural Competency 201 in 2007. The results will give direction to planning activities for the 2008 Cultural Competency program, including designing trainings and development of resource materials.

The same survey instrument was used in the 2006 and in 2007 trainings, i.e. The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) developed by Dr. Josepha Campinha-Bacote (permission granted by Dr. Campinha-Bacote). 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 four-point likert scale. Mean scores were used to determine the percentage of attendees that understood the cultural constructs and their overall level of cultural competence, i.e. "cultural proficiency", "cultural competence", "cultural awareness", or "cultural incompetence" (Campinha-Bacote, 2003, p. 111). Questions in which less than one-half of staff chose answers scored at three or four points on the likert scale are identified as areas in need of improvement, which was the same criterion used in 2006. Deficiencies identified in the 2006 report are compared with the results of the 2007 data.

**Cultural awareness:** There is a statistically significant progressive increase in the mean score for questions relating to cultural awareness (65.7%; 67.0%; and 71.2%, respectively). The data from the three surveys indicate that WIC staff have become significantly more familiar (22%; 36%; 87%, respectively) with issues that may deter cultural groups from seeking healthcare, which was, in 2006, identified as an area of improvement. Although more than one-half of the Cultural Competency 101 participants indicated an awareness of their own prejudices and biases, Cultural Competency 201 attendees showed significant improvement (56% and 72%, respectively) in developing self awareness.

**Cultural knowledge:** There is a statistically significant progressive increase in the mean score for questions relating to cultural knowledge (48.9%; 53.3%; and 61.6%, respectively). Clinical concepts related to cultural competence were challenging for WIC staff, i.e. the structural and cultural variation in drug responses; differences in expression of phenotype and genotype; and diseases that are more prevalent among certain ethnic or cultural groups. The 2007 results showed a statistically significant improvement in staff's knowledge of these concepts. However, more than half of WIC staff still scored poorly (less than three on the likert scale). A notable improvement over last year is WIC staff's significantly increased familiarity with the guiding principals, beliefs, and value systems of more than one cultural group. Cultural Competency 101 pre-test results indicated that 24% of participants were weak in this area. After attending Cultural Competency 201, 51% of WIC staff rated themselves as knowledgeable about different ethnic or cultural groups.

**Cultural skill:** There is a statistically significant increase in the mean score for questions relating to cultural skill between the Cultural Competency 201 pre-test and post-test (61.4% and 69.1%, respectively). This improvement reflects increased awareness of cultural assessment tools and their limitations, as well as an increased confidence in conducting cultural assessments. WIC staff scored well on all concepts related to cultural skill.

**Cultural encounters:** Scores relating to cultural encounters varied across the three surveys (67.3%; 66.8%; and 69.1%, respectively). Less than one-third of all participants across the three surveys (18%; 17%; 21%, respectively) have cross-cultural interactions outside of their practice settings.

More than nine out of ten (93%; 95%; and 97%, respectively) WIC staff are aware of the need to improve their cultural competence and look for opportunities to educate themselves about other cultures.

**Cultural desire:** WIC staff repeatedly demonstrated their desire to become culturally competent. They scored highest for questions relating to cultural desire on all three surveys (79.9%; 81.1%; and 82.1%, respectively). The data showed no areas in need of improvement.

### *Level of Cultural Competence*

Data demonstrates that WIC staff significantly improved their level of cultural competence as a result of the Cultural Competency 101 and 201 trainings. Staff scored significantly higher on each of the three surveys. The mean score for staff was 2.59 in 2006, 2.65 for the Cultural Competency 201 pre-test, and 2.8 on the Cultural Competency 201 post-test. A mean score between 2.00 and 2.99 correlates to a cultural competence level of "culturally aware". WIC staff are making positive changes, and the data indicate that the trainings are successful. However, only 32.8% of staff are providing culturally competent care.

## Recommendations

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

***1) Develop "Cultural Competency 301":*** A frequent suggestion on the evaluation forms, and logical next step in the series of trainings, was to allocate an entire workshop day devoted to food and nutrition, specifically cooking demonstrations, food and spice samples, recipes, and nutritional analysis information for popular foods specific to each culture. Another suggestion was to include speakers from different cultures may facilitate WIC staff to have cultural encounters beyond their professional obligations. Interacting with these speakers will also contribute to their cultural knowledge. Deficits discussed in the sections on cultural knowledge and cultural encounters contribute to the limited number of staff who scored as culturally competent. Therefore, additional trainings that facilitate cultural encounters and improve cultural knowledge are priority areas. The following topics and activities are suggested for Cultural Competency 301:

- Cultural knowledge: spirituality, ethnic pharmacology, and disease prevalence
- Cooking demonstrations, food and spice samples, and nutritional analysis information
- Indigenous speakers from local communities

***2) Provide Cultural Competency 101 and 201 Annually:*** To maintain the progress that Missouri WIC's Cultural Competency has accomplished since its inception, staff new to WIC will need the information presented in Cultural Competency 101 and Cultural Competency 201. These trainings could be offered annually across the six districts, either as two separate one day trainings or as single two-day trainings. These trainings could also serve as refresher courses for current WIC staff.

***3) Write an Article for Publication:*** Cultural Competency 101 addressed cultural awareness, Cultural Competency 201 focused on cultural knowledge and skill and Cultural Competency 301 could facilitate cultural encounters through speakers from other cultures. If Missouri WIC sponsors a Cultural Competency 301, then four of the five components of Dr. Campinha-Bactoe's model will have been taught. An article on Missouri WIC's Cultural Competence program could be submitted to the medical, nursing, and/or nutrition literature for consideration.

# I. Purpose of the Survey

The 2007 Missouri WIC Staff Cultural Competency Survey is a follow-up to the 2006 Missouri WIC Professional Staff Cultural Competency Survey. The purpose of the 2007 Missouri WIC Professional Staff Cultural Competency Survey was to determine whether or not there have been improvements in the level of cultural competence among local Missouri WIC agency during three survey periods: Cultural Competency 101 in 2006, as well as the pre-tests and post-tests given during Cultural Competency 201 in 2007. The results will give direction to planning activities for the 2008 Cultural Competency program, including designing trainings and development of resource materials.

# II. Introduction

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. Missouri WIC initiated the Cultural Competence program, designed for local WIC agency staff in 2006. One component of this program was the development of Cultural Competency 101, a one-day introductory training for staff that focused on learning the basic concepts of cultural competence and developing cultural awareness. The attendees of Cultural Competency 101 completed one cultural competence survey that was distributed and collected prior to the first speaker. The results from this pre-test are discussed in the Report on the 2006 Missouri WIC Professional Staff Cultural Competency Survey (Curtis, 2006). As a result of the success of Cultural Competency 101, Missouri WIC continued the Cultural Competence program in 2007 and, in collaboration with the consultant, created Cultural Competency 201: What Nutrition Staff Need to Know. Cultural Competency 201 was designed to increase cultural knowledge and develop cultural skill. The training addressed cultural issues for selected populations, specifically African Americans, Muslims (Somalis, Bahraini, Iranians, and Bosnian immigrants or refugees), Asians (Chinese, Koreans, and Vietnamese), Mexicans, and Russians. Content covered communication styles, health care practices, attitudes toward and behaviors of indigenous health care practitioners, maternal health beliefs and customs, and nutrition practices. Attendees of *Cultural Competency 201* completed pre-tests and post tests. The results of the three surveys are presented in this report. Deficiencies identified in the 2006 report are compared with the results of the 2007 data.

New statistics regarding the prevalence of racial and ethnic groups in Missouri have not been released since the publication of the 2006 report, nor has new information about cultural competence been published in the last year. Demographic and cultural competency information is presented in more detail in the Introduction section in the Report on the 2006 Missouri WIC Professional Staff Cultural Competency Survey (Appendix A). This section reviewed the cultural landscape in Missouri, a brief overview of cultural competence, and its affect on quality of care (Curtis, 2006, p 5-6).

# III. Methods

## Survey Design

The same survey instrument was used in the 2006 and in 2007 trainings, i.e. The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) developed by Dr. Josepha Campinha-Bacote (permission granted by Dr. Campinha-Bacote). The survey instrument is based on her model of cultural competence for health care providers and consists of five interdependent constructs:

- ***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).

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 four-point likert scale. Scores indicate if the staff member is functioning at a level of "cultural proficiency", "cultural competence", "cultural awareness", or "cultural incompetence" (Campinha-Bacote, 2003, p. 111).

## Data Collection

WIC staff were invited to attend one of the Cultural Competency training seminars provided in the six WIC district areas. Self-administered surveys were distributed and collected during the 2006 Cultural Competency 101 training and during the 2007 Cultural Competency 201. The 2006 surveys requested information about the participants' primary job title and credentials. Results indicated that participants were employed as WIC administrators, WIC coordinators, nutrition coordinators, Competent Professional Authorities (CPAs), Health Professional Assistants (HPAs), WIC certifiers, breastfeeding coordinators, breastfeeding peer counselors, and WIC receptionists. 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). This question was omitted from the 2007 survey, however, many of the participants of the Cultural Competency 201 training informally identified themselves as fulfilling one of the positions listed above.

### *Data Entry & Analysis*

WIC and Nutrition Services created a database in Microsoft Access and used double data entry to reduce the number of data entry errors. Primary data cleansing was conducted by WIC and Nutrition Services; a secondary cleansing was conducted by the consultant using Microsoft Excel. The clean 2007 data was added to the 2006 SPSS 12.0 for Windows file. The consultant conducted a statistical analysis of the data using SPSS. Due to the high proportion of surveys with missing data (discussed in more detail in the next section), a mean score was used to determine the percentage of attendees that understood the cultural constructs and their overall level of cultural competence. Graphs with statistically significant ($p \leq .05$) changes between the three data collection periods are denoted with an asterisk. Please refer to Appendix B for the corresponding tabular data.

# IV. Results

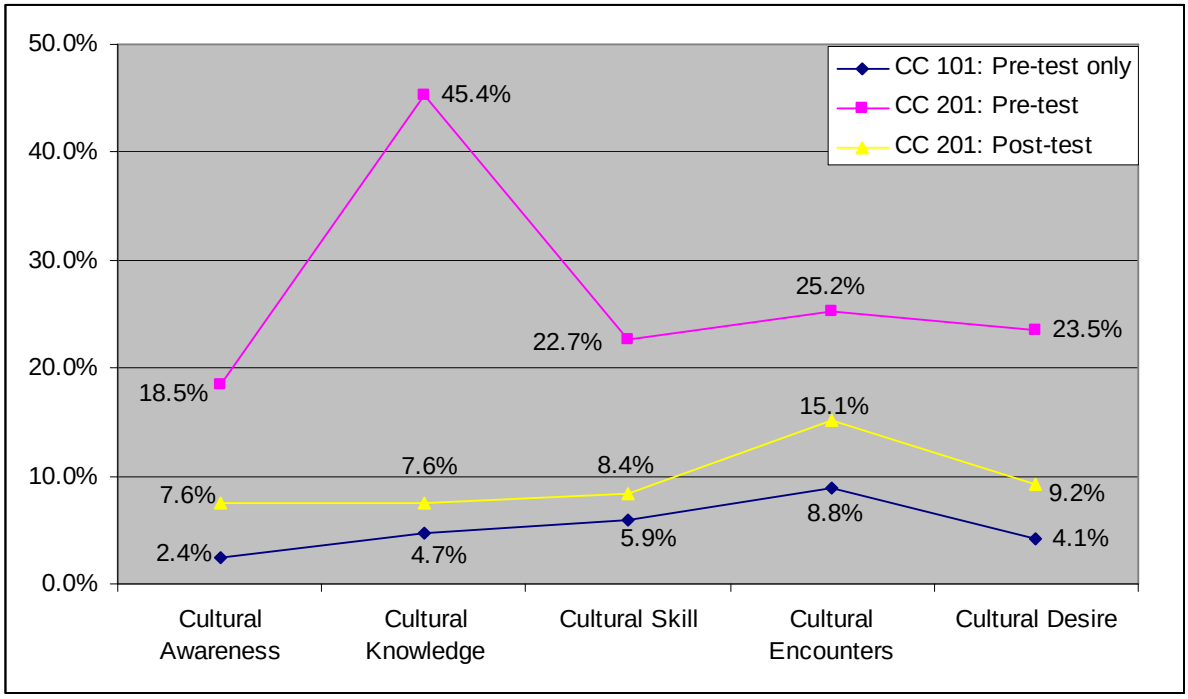
A total of 408 surveys were analyzed: 170 pre-tests from Cultural Competency 101 (CC101); 119 pre-tests from Cultural Competency 201 (CC201); and 119 post-tests from Cultural Competency 201 (Figure 1). More than one-third of the surveys (35.8%) were missing answers to one or more questions. Cultural Competency 201 pre-tests contained more incomplete answers than the other two surveys (Figure 2), with questions representing the construct of cultural knowledge missing the most data. One question within this construct addresses cultural differences and may have used terminology that was unfamiliar to survey participants. One-third (32.8%) did not answer this question on their pre-test. Since the corresponding data point for the Cultural Competency 201 post-test is more in line with the Cultural Competency 101 pre-test data point, it appears that more participants understood this terminology after the training.

**Figure 1. Data Collection Periods and Number of Surveys Analyzed**

| Name of Training | Data Collection Period(s) | Type of Survey | Number of Surveys Analyzed |
|---|---|---|---|
| Cultural Competency 101 | July 2006 & Sept. 2006 | Pre-test | 170 |
| Cultural Competency 201: What WIC Staff Need to Know | July 2007 | Pre-test | 119 |
| Cultural Competency 201: What WIC Staff Need to Know | July 2007 | Post-test | 119 |
| **Total** | | | **408** |

The data may reflect a self-report bias since the IAPCC-R is a self-administered survey. Self-selection bias is another limitation. Those who registered for the Cultural Competency 101 and Cultural Competency 201 trainings may have a greater interest in the topics than those who did not register; therefore, the data is not generalizable to all Missouri WIC staff.

**Figure 2. Proportion of Unanswered Questions by Cultural Construct and Data Collection Period**



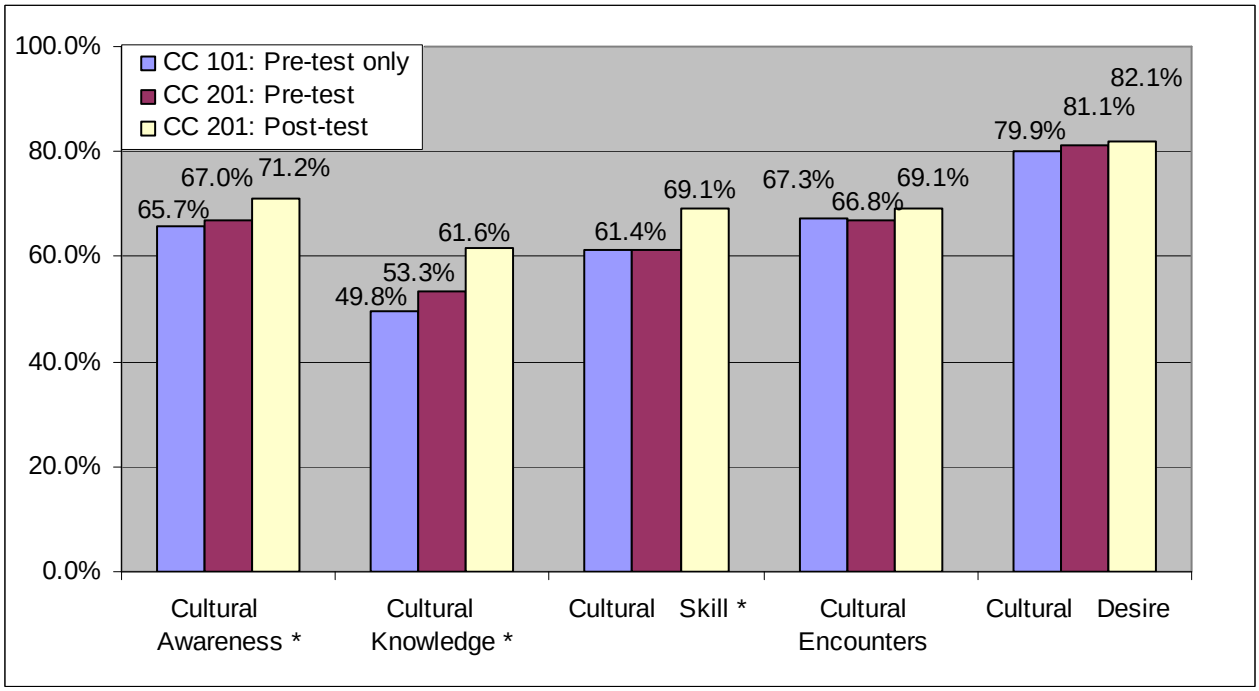

# V. Findings & Discussion

Cultural Competency 101 was an introduction to the concepts of cultural competency and focused on developing cultural awareness, which is the first step in the process of becoming culturally competent. Cultural Competency 201 built upon the concepts presented in Cultural Competency 101 by focusing on improving cultural knowledge and developing cultural skill. The 2006 pre-assessment survey showed that cultural knowledge and cultural skill were the areas in greatest need of improvement.

## *Understanding the Five Cultural Constructs*

The IAPCC-R 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 staff's score on the individual constructs (see Figure 3). Questions in which less than one-half of staff chose answers scored at three or four points on the likert scale are identified as areas in need of improvement, which was the same criterion used in 2006. The following section reports the mean score for the entire survey, corresponding to their level of cultural competence.

**Figure 3. Percent Understanding of the Five Cultural Constructs by Data Collection Period**




## Cultural awareness

There is a statistically significant progressive increase in the mean score for questions relating to cultural awareness (65.7%; 67.0%; and 71.2%, respectively). The data from the three surveys indicate that WIC staff have become significantly more familiar (22%; 36%; 87%, respectively) with issues that may deter cultural groups from seeking healthcare, which was, in 2006, identified as an area of improvement. Although more than one-half of the Cultural Competency 101 participants indicated an awareness of their own prejudices and biases, Cultural Competency 201 attendees showed significant improvement (56% and 72%, respectively) in developing self awareness, an integral part of becoming culturally aware. Pre-test results in 2006 and 2007 showed that nine out of ten staff understood that a person's culture is influenced by a wide range of characteristics, such as political beliefs, sexual orientation, level of education, age, gender, and marital status are just a few of the cultural characteristics that may influence one's culture. Cultural Competency 201 post-test results indicated that this proportion decreased significantly to 79%. Since WIC staff demonstrated a strong understanding of this concept in both pre-tests, it is possible that staff misread the question as they were completing the Cultural Competency 201 post-test.

## Cultural knowledge

There is a statistically significant progressive increase in the mean score for questions relating to cultural knowledge (48.9%; 53.3%; and 61.6%, respectively). The 2006 data indicated that staff were most deficient in the area of cultural knowledge. Therefore, increasing cultural knowledge was one goal of the Cultural Competency 201 training. Clinical concepts related to cultural competence were challenging for WIC staff, i.e. the structural and cultural variation in drug responses; differences in expression of phenotype and genotype; and diseases that are

more prevalent among certain ethnic or cultural groups. The 2007 results showed a statistically significant improvement in staff's knowledge of these concepts; however, more than half of WIC staff still scored poorly (less than three on the likert scale).

A notable improvement over last year is WIC staff's significantly increased familiarity with the guiding principals, beliefs, and value systems of more than one cultural group. Cultural Competency 101 pre-test results indicated that 24% of participants were weak in this area. After attending Cultural Competency 201 and receiving information about the communication styles, health care practices, attitudes toward and behaviors of indigenous health care practitioners, maternal health beliefs and customs, and nutrition practices for nine different cultural or ethnic groups served by Missouri WIC 51% of WIC staff rated themselves as knowledgeable about different ethnic or cultural groups.

### Cultural skill

Developing cultural skill was another goal of Cultural Competency 201. There is a statistically significant increase in the mean score for questions relating to cultural skill between the Cultural Competency 201 pre-test and post-test (61.4% and 69.1%, respectively). This improvement reflects their increased awareness of cultural assessment tools and their limitations, as well as an increased confidence in conducting cultural assessments. The Cultural Competency 201 training manuals included a series of questions for each topic addressed in the training, i.e. questions that could be used in a cultural assessment. WIC staff worked in small groups to create customized cultural assessment tools based on these questions and shared with all groups. WIC staff scored well on all concepts related to cultural skill.

### Cultural encounters

Scores relating to cultural encounters varied across the three surveys (67.3%; 66.8%; and 69.1%, respectively). Less than one-third of all participants across the three surveys (18%; 17%; 21%, respectively) have cross-cultural interactions outside of their practice settings. Many WIC clinics are located in rural areas and staff may have few opportunities to have face-to-face interactions with members of different cultural or ethnic groups. More than nine out of ten (93%; 95%; and 97%, respectively) WIC staff are aware of the need to improve their cultural competence and look for opportunities to educate themselves about other cultures.

### Cultural desire

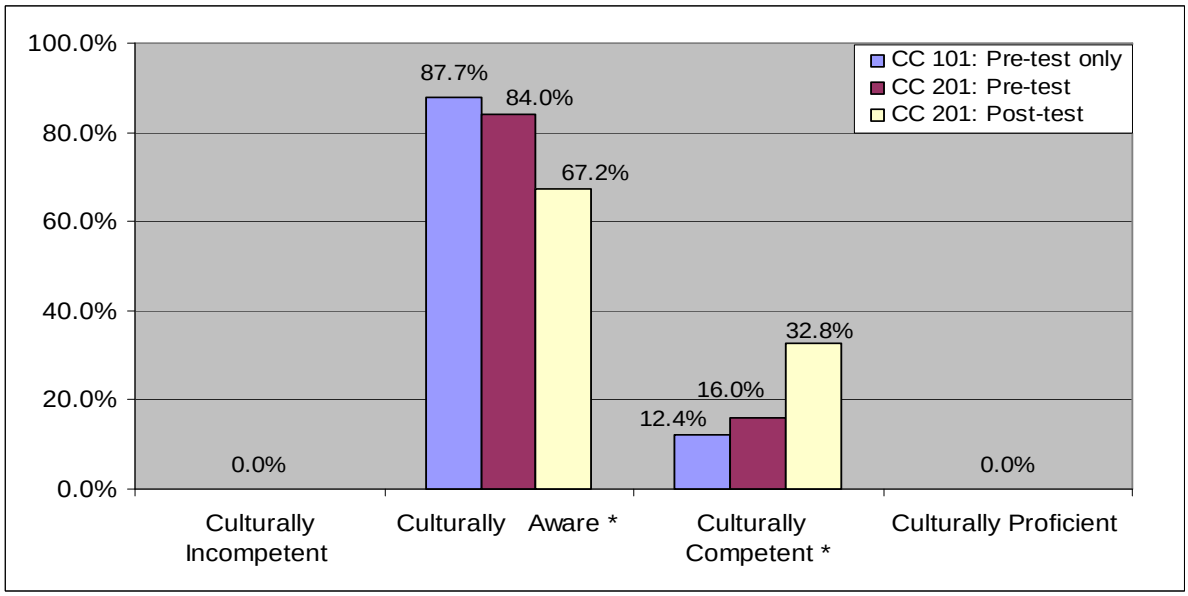
WIC staff repeatedly demonstrated their desire to become culturally competent. They scored highest for questions relating to cultural desire on all three surveys (79.9%; 81.1%; and 82.1%, respectively). The data showed no areas in need of improvement.

## *Level of Cultural Competence*

Staff scored significantly higher on each of the three surveys. The mean score for staff was 2.59 in 2006, 2.65 for the Cultural Competency 201 pre-test, and 2.8 on the Cultural Competency 201 post-test. A mean score between 2.00 and 2.99 correlates to a cultural competence level of "culturally aware". Figure 4 reflects this significant shift towards cultural competence. WIC staff are making positive changes, and the data indicate that the trainings are successful. However, only 32.8% of staff are providing culturally competent care. Mean

scores combined with their scores on the individual constructs suggest that WIC staff may continue to benefit from additional cultural competency training, specifically trainings focused on developing clinical cultural knowledge and facilitating cultural encounters.

**Figure 4. Percent Score by Level of Cultural Competence and Data Collection Period**




# VI. Recommendations

## *Develop "Cultural Competency 301"*

Data demonstrates that WIC staff significantly improved their level of cultural competence as a result of the Cultural Competency 101 and 201 trainings. The Cultural Competency 101 and Cultural Competency 201 trainings provide an excellent foundation on which to build. WIC staff may further improve their level of cultural competence with a third workshop, Cultural Competency 301. A frequent suggestion on the evaluation forms, and logical next step in the series of trainings, was to allocate an entire workshop day devoted to food and nutrition, specifically cooking demonstrations, food and spice samples, recipes, and nutritional analysis information for popular foods specific to each culture. Food is a tangible part of culture that can greatly enhance the learning experience. Cooking demonstrations, sampling, and the consequent discussion time could easily be incorporated into a one-day training. WIC staff also requested that trainings be longer to allow more time to learn the large amount of content. When asked informally, many WIC staff responded they would be willing to attend a two-day training.

Another suggestion was to include speakers from the various cultures. Since more than two-thirds of WIC staff have cross-cultural interactions only through WIC, including speakers from different cultures may facilitate WIC staff to have cultural encounters beyond their professional obligations. Many WIC staff stated that the information presented in Cultural

Competency 101 and Cultural Competency 201 was interesting and informative, however this information was mostly research studies and/or personal experiences of someone outside of the targeted cultures. Staff would like to be exposed to the knowledge and insights of those who are native to the various cultures served by WIC. Interacting with these speakers will also contribute to their cultural knowledge. The deficits discussed in the sections on cultural knowledge and cultural encounters contribute to the limited number of staff who scored as culturally competent. More than two-thirds of WIC staff do not score as culturally competent. Because of these results, additional trainings that facilitate cultural encounters and improve cultural knowledge priority areas. The following topics and activities are suggested for Cultural Competency 301:

- Cultural knowledge: spirituality, ethnic pharmacology, and disease prevalence
- Cooking demonstrations, food and spice samples, and nutritional analysis information
- Indigenous speakers from local communities

### *Provide Cultural Competency 101 and 201 Annually*

Missouri WIC's Cultural Competency program is making steady progress. If this progress is to be maintained, staff new to WIC will need the information presented in Cultural Competency 101 and Cultural Competency 201. These trainings could be offered annually across the six districts, either as two separate one day trainings or as single two-day trainings. These trainings could also serve as refresher courses for current WIC staff.

### *Write an Article for Publication*

Cultural Competency 101 addressed cultural awareness, Cultural Competency 201 focused on cultural knowledge and skill and Cultural Competency 301 could facilitate cultural encounters through speakers from other cultures. If Missouri WIC sponsors a Cultural Competency 301, then four of the five components of Dr. Campinha-Bactoe's model will have been taught. Although not exhaustive, searches of the Journal of the American Dietetics Association and Today's Dietitian, as well as a general search of PubMed revealed that the literature contains many articles about the need for cultural competence, but few discuss addressing most of the components of a specific model over time. An article on Missouri WIC's Cultural Competence program could be submitted to the medical, nursing, and/or nutrition literature for consideration.

# VII. References


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.

Curtis, T. (2006). *Report on the 2005 Missouri WIC Professional Staff Cultural Competency Survey,* pgs 5-6. WIC and Nutrition Services, Missouri Department of Health and Senior Services.

Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)*, 2001. Retrieved on September 8, 2007 from: http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3.

# Appendix A: Cultural Diversity and Cultural Competency in Missouri

*This section is an excerpt from the Introduction of the Report on the 2006 Missouri WIC Professional Staff Cultural Competency Survey (Curtis, 2006, p. 5-6)*

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.

# Appendix B: Tabular Data for Graphs

**Table 1. Number and Proportion of Unanswered Questions by Cultural Construct and Data Collection Period**

| | CC 101 | | CC 201: Pre-Test | | CC 201: Post-Test | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| Cultural Awareness | 4 | 2.4% | 22 | 18.5% | 9 | 7.6% |
| Cultural Knowledge | 8 | 4.7% | 54 | 45.4% | 9 | 7.6% |
| Cultural Skill | 10 | 5.9% | 27 | 22.7% | 10 | 8.4% |
| Cultural Encounters | 15 | 8.8% | 30 | 25.2% | 18 | 15.1% |
| Cultural Desire | 7 | 4.1% | 28 | 23.5% | 11 | 9.2% |

**Table 2. Percent Understanding of the Five Cultural Constructs by Data Collection Period**

| | Cultural Awareness * | Cultural Knowledge * | Cultural Skill * | Cultural Encounters | Cultural Desire |
|---|---|---|---|---|---|
| CC 101: Pre-test only | 65.7% | 49.8% | 61.4% | 67.3% | 79.9% |
| CC 201: Pre-test | 67.0% | 53.3% | 61.4% | 66.8% | 81.1% |
| CC 201: Post-test | 71.2% | 61.6% | 69.1% | 69.1% | 82.1% |

**Table 3. Percent Score by Level of Cultural Competence and Data Collection Period**

| | Culturally Incompetent | Culturally Aware * | Culturally Competent * | Culturally Proficient |
|---|---|---|---|---|
| CC 101: Pre-test only | 0.0% | 87.7% | 12.4% | 0.0% |
| CC 201: Pre-test | 0.0% | 84.0% | 16.0% | 0.0% |
| CC 201: Post-test | 0.0% | 67.2% | 32.8% | 0.0% |

# 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 September 8, 2007.*

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.