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Cultural Competence Among Oncology Health Care Providers

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CULTURAL COMPETENCE AMONG
ONCOLOGY HEALTH CARE PROVIDERS

_________________________________________

A Project
Presented to the
Faculty of
California State University,
San Bernardino

_________________________________________

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

_________________________________________

by
Junelle Flerry Gemarino

June 2014
CULTURAL COMPETENCE AMONG ONCOLOGY HEALTH CARE PROVIDERS

A Project
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Dr. Rosemary McCaslin, Research Coordinator, M.S.W
ABSTRACT

The purpose of the study was to examine cultural competence among oncology health care providers. Specifically, the study assessed how career type, presence of previous diversity training, and education affected overall cultural competence of oncology health care providers.

The study used a quantitative survey design with self-administered questionnaires. A total of 36 voluntary oncology health care providers completed the cultural competence assessment survey. Participants were asked of their cultural awareness/sensitivity, cultural behaviors, previous experiences of diversity trainings, and some demographics questions. Descriptive (e.g. mean, frequency distributions) and inferential (e.g. t-test, one-way analysis of variance) statistics were used to analyze the data.

Findings of the study showed that the levels of cultural competence among oncology health care providers were low to moderate. Oncology health care providers who were social workers and registered nurses tended to report more frequent culturally competent behaviors, compared to other career types of health care providers. The study also
found that those who had specific previous diversity training tended to report higher levels of cultural competence compared to those who did not have those diversity trainings. Findings of the study suggest that there be a need for improvement in the cultural competency practice among oncology health care providers. The results of this study could serve as a reference in the initial evaluation of exploring cultural competency health care practice in the specialization of oncology.
ACKNOWLEDGEMENTS

I would like to thank Kaiser Permanente Oncology Clinic in Riverside for allowing me to be an Intern. I appreciate the opportunity to be a part of this wonderful department. To all of the health care providers, I appreciate the amazing care you provide to your patients - you all are an inspiration. To all of the participants of my project who took the time to complete my questionnaire, this would not be made possible without your help and I thank you all very much. I would also like to take this time to acknowledge and appreciate my research advisor, Professor Janet Chang. Thank you so incredibly much for your guidance, patience, and support. Lastly, to my friends and family: Angelo, Nicole, and Auntie Noeme, thank you for supporting me in everything, I love you all.
DEDICATION

I dedicate this study to the enhancement and improvement of treatment for all Cancer Patients and to the hard working professionals that are compassionate and devoted in providing care for others. I also dedicate this project to my mother, who was also a health care provider, cancer patient, and a wonderful human being that left the world too soon. I believe that she would have been proud of me. Not only from graduating with a Masters of Social Work but growing as an individual, as a young woman, and as a professional. In the future, I hope to continue to contribute further to social work research and be involved in projects and studies that focus on helping others.
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CHAPTER ONE
INTRODUCTION

The contents of Chapter One introduce an overview of the population being studied. An examination of the study’s purpose is further discussed. Finally, the chapter will conclude with the significance of the project for social work.

Problem Statement

The United States (US) is growing to be more diverse every day. It is composed of humans with various ethnicities, cultural backgrounds, socioeconomic status, sexual preferences, and religious/spiritual beliefs. Smith (2013) defines culture as being far more than race, ethnic background, and language. It is the dynamic and ever-changing totality of a person’s physiologic and psychological perceptions and experiences. With a growing multicultural society, the delivery of health care services must also have a multicultural competent approach, and more specifically, with persons who have cancer.

The American Cancer Society (ACS) (2013) defines cancer as a group of diseases characterized by uncontrolled
growth and spread of abnormal cells. Anyone can be at risk of cancer. It is estimated that approximately 1.6 million Americans are expected to be diagnosed with cancer within the year of 2013. This figure will be added to the already overwhelming number of more than 13.7 million living Americans with a history of cancer.

The ACS (2013) understands that there is a clear health disparity with cancer amongst persons with low socioeconomic status and racial/ethnic minorities. Those factors that perpetuate health disparities include the following: inequities in work, wealth, income, education, housing, and overall standards of living. In addition to social barriers to high quality cancer prevention, early detection and treatment services (ACS, 2013). In 2011, the presidential panel of the ACS reported specifically about cancer disparities,

To fill the gaps, recommendations from the panel include more research, evaluation of current screening guidelines, standardized definitions of race and ethnicity that describe different populations in a more meaningful way, trained translators for patients who don’t speak English, and cultural competency training for health care providers. (ACS, 2011)
The issue of the sociocultural barriers to high quality service and care may be attributed to poor cultural competency in the health care system. Moreover, sociocultural barriers may also affect the oncologic patient outcomes in treatment or access to treatment.

There are numerous studies describing cultural competence and the application of cultural competence in the health care setting. According to clinical psychologist, Sperry (2012), "cultural competence is defined as the capacity and capability to recognize, respect and respond with appropriate action to the needs and concerns of individuals from different, ethnicities, social classes, genders, generations, or religions" (pg. 48). This author also suggests that cultural knowledge, cultural awareness, cultural sensitivity, and cultural action are all components of cultural competence.

According to the interviewed experts on health care in the article by Betancourt, Green, and Carillo (2002), they viewed cultural competency as a way to increase access to quality of care for all patient populations and as a business imperative to respond to diverse patient populations and attract new patients and market share. The authors also identified sociocultural barriers that may be
contributing to poor care quality and racial/ethnic health care disparities. Those barriers included the following: the lack of diversity in health care leadership and workforce, systems of care poorly designed for diverse patient populations, and poor cross-cultural communication between providers and patients. Health care experts state that cultural competence at the clinical and systematic level will improve quality of care and eliminate racial/ethnic disparities, in the hope of an overall positive patient outcomes for the minority population (Betancourt et al., 2002).

Betancourt, Green, Carrillo, and Park, (2005) similarly interviewed informants about cultural competency in relation to government. Informants saw cultural competence as a method of increasing access to quality care for all populations. Health care purchasers can help stimulate change if they understood the impact of disparities on cost and quality of health care, and how cultural competence can address these issues. As cited from by Betancourt et al. (2005), the Health Resources and Services Administration has developed a Health Disparity Collaborative focusing on interventions at community health centers.
Purpose of the Study

The purpose of this study was to assess cultural competence of health care providers in an outpatient clinic setting, in order to implement proper cultural responsive interventions with the intent to improve the quality of care and service for oncologic patients. More importantly, appropriate application cultural competence care may improve the quality of life for cancer patients.

According to The Offices of Minority Health (2013), cultural competency is vital to minority health because it is a factor in eliminating disparities in health care. It enhances healthy communication between patients and physicians, which may have a positive effect on health outcomes within the minority population. Identifying the level of cultural competence of oncologic health care providers will be a step forward in closing the disparities gap in health care by singling out the characteristics that are significant. This knowledge may be helpful in designing a future educational plan for oncologic providers to increase cultural competence. This study used valid and reliable survey instruments of measuring cultural competency among oncology health care providers, which was efficient in time and resources.
A quantitative study was conducted to assess the cultural competence of oncologic health care providers. A survey was distributed to health care providers of the oncology medical facility at Kaiser Permanente in Riverside, California. This instrument measured cultural competence at two subscales: cultural awareness/sensitivity and cultural competent behaviors. Demographic questions that are in the survey will be covering specific characteristics (e.g. age, gender, and educational levels), recent cross-cultural experiences, self-assessment in cultural competence, and prior cultural competence training.

Significance of the Project for Social Work

Hopefully, this project improved many aspects in social work and expand the existing literature of oncologic social work. This project’s significance to social work is measured whether the ongoing cultural competence training should be applied in oncologic health care settings. Exploring cultural competence amongst oncologic health care providers may help improvement in quality of care to patients and their families. This information of cultural competence among oncologic care providers may also help
improvement in clinical outcomes if practiced with culturally congruent care. Furthermore, if so, should cultural competence training be a need in other clinical settings, policies should be implemented.

This study of cultural competence amongst oncology health care providers informed in all phases of the generalist model in social work (e.g. engagement, assessment, planning, implementation, evaluation, termination, and follow-up). The reason being is because cultural competence can be, and is, an intervention that is ongoing process throughout the treatment phases. The research questions of this study are to (1) determine the cultural competence level of oncology health care providers, (2) determine whether current career title of oncologic health care providers influence cultural competence, (3) determine whether prior diversity training influence levels of cultural competence, and (4) determine whether cultural competence among oncology health care providers is related to educational factors and other personal characteristics.
CHAPTER TWO
LITERATURE REVIEW

Introduction

A reasonable amount of empirical data has been researched in the recent years identifying the relationship of cultural competence in the health care setting. This chapter is divided into three subsections: findings of cultural competence amongst nurses, findings of cultural competence amongst health care professionals, and theories guiding conceptualization.

Cultural Competence Among Nurses

Nurses are the frontline of interactions with patients and clients. It is essential that cultural competence practice is applied in the engagement with the diversity of patient populations. There are some studies that show the necessary relationship with cultural competence and practicing nurses.

Health care professionals, such as nurses, need to be able to understand the importance of cultural competency in nursing practice. Studies such as Alrems’ (2012) have shown the link of cultural competence/knowledge and attitudes
towards their oncologic patient’s pain. The quantitative instrument that was used, the cultural competence assessment, was developed by Doorenbos, Schim, Benkert, and Borse (2005). Alrems (2012) collected surveys from 320 oncology nurses and found a positive correlation that showed the oncology nurses who were more culturally aware and sensitive tended to have more positive attitudes towards cancer pain management, resulting in more positive patient outcomes. This author suggests a link of knowledge to cancer pain management to some component of cultural competence with oncologic nurses (Alrems, 2012).

Another study that examined the cultural competent behaviors and nurses, focused on the underrepresented nurses was Benkert, Templin, Schim, Doorenbos, and Bell (2011). This study cited using the framework developed by Schim, Doorenbos, Benkert, and Miller (2007), which will later be discussed in the chapter. The authors researched the culturally competent behaviors of three underrepresented groups of nurse practitioners through quantitative measures (questionnaires). The three groups were non-Hispanic white males (270), Asian American males and females (90), and African American males and females (114). Findings revealed that life experiences with
diversity training had a direct effect on cultural awareness/sensitivity and culturally competent behaviors. In addition, diversity training had a direct effect on cultural competent behaviors. The authors stated that diversity training is an important predictor of cultural competent behaviors, as well as concluded that the findings were similar with samples of ethnically homogenous samples (Benkert et al., 2011).

Waite and Calamaro (2010) discussed the important issues regarding cultural competence in nursing education. This study reported that nurses believed they are less confident and inadequately prepared to provide culturally competent care to patients from diverse cultures, regardless of their educational and demographic background. The authors also reported that the nursing population remains a homogenous group, with nurses of White racial/ethnic background being the majority (88.4%), and the second largest group (4.6%) are nurses of Black or African American background. The study suggests cultural encounters may enhance the nursing student’s abilities to demonstrate attentiveness, genuine concern, presence, warmth, and empathy. More importantly, nurses who practice from a conceptual framework of diversity and cultural
competence will potentially influence health care, which will decrease health disparities and diminish cultural incompetence (Waite & Calamaro, 2010).

Similarly, Reeves and Fogg (2006) conducted a mixed methods study exploring the perceptions of graduating nursing students (n=13) regarding life experience and cultural competence. The study used the framework of Campinha-Bacote’s model of cultural competence, as well as Campinha-Bacote’s Inventory for Assessing the Professional Cultural Competence instrument. About half of the participating students felt they lacked adequate cultural knowledge to provide cultural competent care. Additionally, the majority of the participating students felt uncomfortable providing care to clients of diverse background different from themselves. The authors found that there were three types of life patterns relating to cultural experiences that emerged during the interviews; these types were positive, neutral, and conflicted life experiences. Findings suggested that life patterns affected the nursing students’ interest and desire to provide culturally competent care. The suggestions from this study included educating nursing students on how to use culturally appropriate assessment tools in practice,
teaching the students how to become culturally aware, and expanding cultural education further to areas such as, sexual orientation and religion/spirituality (Reeves & Fogg, 2006).

Ingram (2011) took a further look at cultural competence and discussed its relation to health literacy among the minority and diverse populations in nursing practice. The study cited the National Assessment of Adult Literacy by defining health literacy as having the ability to use the literacy skills to read and understand health information in daily encounters. The author suggested that health literacy and cultural competence are related. Moreover, both concepts use effective and appropriate interventions based on a holistic assessment and incorporation of cultural elements in the design, planning, implementation, and evaluation of person’s health care issues and concerns. Campinha-Bacote’s model of Process of Cultural Competence has five constructs: cultural awareness, cultural skills, cultural knowledge, cultural encounters, and cultural desire. The author added the use of Campinha-Bacote’s Process of Cultural Competence model for nurses to incorporate culturally appropriate assessments and disseminating health care information at
appropriate literacy levels in caring for ethnic minorities (Ingram, 2011).

Cultural Competence Among Health Care Professionals

Nurses are not exclusive in the interaction with patients. Other health care providers are involved in the patient health care activities such as diagnoses, charting vital signs, and psychosocial assistance. Interactions with health care providers can make a patient feel accepted or not accepted. With a diverse population, it is important for health care providers to be culturally competent.

Among hospice care providers Schim, Doorenbos, and Borse (2006) had studied cultural competence by using quasi-experimental, longitudinal, crossover designs to test the effects of an educational interventions for a multidisciplinary team. This study had 130 care providers that were from hospice agencies. Participants were pre-tested, organized into random groups, had one of the two educational trainings (ethics or cultural competence), post-tested, were trained in the other educational program, lastly, and were post-tested again. The findings demonstrated that improvements of cultural competence were observed. Although, the authors were interested in whether
the changes seen with a small intervention would achieve to be lasting cultural competent behaviors (Schim et al., 2006).

Doorenbos and Schim (2004), worked together again in order to study cultural competence among hospice care providers. The purpose of their study was to determine if lack of cultural competence was the link that explain the tendency of ethnic minorities underutilizing hospice services compared to the Caucasian population. The instrument the authors used was a descriptive survey called the cultural competence assessment. The study distributed 125 surveys, and 119 were returned having a response rate of 95%. Findings stated factors such as an increased education, and prior cultural training were significant in predicting cultural competent behaviors. Results indicated that hospice staff needed enhancement of skills used to identify cultural differences and skills on how to be culturally responsive to hospice patients (Doorenbos & Schim, 2004).

Polacek and Martinez (2009) conducted a study assessing the cultural competence of a local hospital system in the US. The purpose of this study was to describe the baseline assessment factor analysis results and to
implement findings to program planning to meet standards of the Office of Minority Health. The authors used both quantitative (employee survey) and qualitative (patient and physician focus groups) approaches in their methods. The study had 156 surveys completed and each focus group had five to eight participants. There was a significant difference in the level of cultural awareness and knowledge by the participant’s employment position. The patient focus groups had shared concern about receiving respect from employees and access to health care. The authors concluded that cultural competency can be improved by cultural education, attention to diversity, and understanding of health disparities (Polacek & Martinez, 2009).

Schim, Doorenbos, and Borse (2005) assessed the cultural competence among health care providers in cities, both in the US (Michigan), and in Canada (Ontario). The purpose of the study was to examine variables associated with cultural competency among health care providers in an urban hospital setting in the US and Canada. The methods used in this study included a cross-sectional descriptive design with a convenience sample. There was 145 providers in total (n = 71 Ontario; n = 74 Michigan). The instrument the authors used was the cultural competence assessment.
Findings included in both countries, participants with a higher level of education and prior diversity training tend to have a higher score on the cultural competence assessment. The factor of higher level of educational attainment may be attributed by more exposure to diverse populations. The cultural competence model that the authors used suggests that the more experienced a health care provider has with diverse clients is associated with a more positive cultural competency score. However, the findings did not show significance (Schim et al., 2005).

Theories Guiding Conceptualization

In 1998, Campinha-Bacote (2002) first developed the process of cultural competence in the delivery of health care services as a model of care. In 2002, this model viewed cultural competency as an ongoing process that the health care professional would continuously strive to achieve to effectively provide appropriate services within the cultural context of the patient. Assumptions of this model include the following:

Cultural competence is a process, cultural competence consists of given constructs (awareness, knowledge, skills, encounters, and desire), there is more
variation within ethnic groups than across ethnic
groups, there is a direct relationship between the
level of competence of health care providers, and
their ability to provide culturally responsive
services; cultural competence is an essential
component in rendering effective and culturally
responsive services to culturally and ethnically
diverse patients. (p. 181)

Campinha-Bacote (2002) also defined the five
constructs of the model. (1) “Awareness is understood as
the self-examination and in-depth exploration of one’s own
cultural and professional background” (p. 182). The health
care provider must recognize his/her own biases,
prejudices, and assumptions of diverse individuals. (2)
“Knowledge is the process of seeking and obtaining a sound
educational foundation about diverse cultural and ethnic
groups” (p. 182). The three issues that a health care
provider can focus in their interventions include the
following: “health-related beliefs and cultural values,
disease incidence and prevalence, and treatment efficacy”
(p. 182). Rather than stereotype clients into one’s
culture, the health care providers should remember every
client is unique with a diverse set of life experiences.


(3) “Skills refer to the ability to collect relevant cultural data regarding the patient’s presenting problem and accurately perform a culturally based assessment” (p. 182). (4) “Encounters refer to the process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds” (p. 182). (5) “Desire is the motivational construct that is the process of health care providers becoming culturally aware, culturally knowledgeable, culturally skillful, and have experience with cultural encounters, not because they have to, rather, because they are willing to improve” (p. 182). All five constructs are interdependent of each other, meaning, that health care providers would have to address each construct to enter the process of cultural competence (Campinha-Bacote, 2002).

In 2011, Campinha-Bacote had updated the model of process of cultural competence in the delivery of health care services. In the most recent revised version of this model, one characteristic was found to be a key construct in the process of cultural competence, which were cultural encounters. Thus, process of being culturally competent begins with cultural encounters. This is the aim of continuously engaging with diverse populations is to
validate, refine, or modify existing values, beliefs, and practices about a cultural group; resulting in the development of cultural desire, cultural awareness, cultural skillfulness, and cultural knowledge. Cultural encounters must be mindful and health care providers need to have presence, meaning being open and available to the patient (Campinha-Bacote, 2011).

Schim, Doorenbos, Benkert, and Miller (2007) developed the Culturally Congruence Care Model. This model has the addition of the client’s perspective which contributes to clients outcomes. Culturally congruent care is the goal of effective interaction between the providers and the patients. The model of culturally congruent care has several assumptions and propositions. Assumptions of this model include the following: (1) “the desired outcome of culturally congruent care must be evaluated from the perspective of the recipients and the providers of care” (p. 108), (2) “specific competencies (cognitive, affective, and psychomotor behaviors) can be defined, learned, and identified in practice” (p. 108), (3) “the scope of competence is related to the number and variety of diverse groups and people encountered in community, social, and/or service contexts” (p. 108), and lastly (4), “the depth of
competence is related to the amount of exposure and type of interaction with particular groups and people encountered in community, social, and/or service contexts” (p. 108). Propositions of the model include the following: (1) “culturally congruent care, with diverse people and groups representing a community of service at a given place and time, is necessary for health service quality” (p. 108), (2) “culturally competent behaviors on the part of providers are necessary but not sufficient to produce culturally congruent care” (Schim et al., 2007, p. 108).

Summary

As identified in the literature, there are different factors that are possibly associated with cultural competency in the health care setting. Cancer survivorship is steadily growing. It is essential and necessary for the evaluation of quality of care and services to culturally diverse populations. There is relevancy in assessing cultural competence among oncology health care providers for the goal of increasing the knowledge of oncologic social work and quality of life to all persons with cancer.
CHAPTER THREE

METHODS

Introduction

This chapter covers the methods used in carrying out this study. This section outlines the study design, sampling, data collection, survey instrument, procedures, and protection of human subjects during the conduction of the study. Finally, the statistical data analysis and quantitative methods process that were studied.

Study Design

The purpose of the proposed study was to evaluate cultural competence among oncology health care providers in an oncology clinic setting. Health disparities among the ethnically and culturally diverse populations are prominent. The implementation of cultural competence in service and care practice may be a viable intervention to combat growing cancer disparities. The focus of the study was to assess the levels of oncologic health care provider’s cultural awareness/sensitivity and culturally competent behaviors.
The study employed a quantitative research design. The standardized survey instrument was initially developed by Schim, Doorenbos, Miller, and Benket (2003) and then revised by Doorenbos, Schim, Benkert, and Borse (2005). This questionnaire assessed health care providers on cultural awareness/sensitivity and competent behaviors. Included are questions on demographic characteristics such as age, gender, race/ethnicity, highest educational achievement, prior cultural diversity training, diversity encounters, and specific career title. This method was chosen because of the need to identify a clearer understanding of specific characteristics that may influence the practice of cultural competence in the health care setting.

There are several limitations of quantitative survey studies. A limitation is the reliance of self-reporting from respondents. Survey researchers may find researcher bias in their study; this is the phenomenon of respondents were trying to please the researcher by providing socially desirable answers to the survey questions; this may not be accurate in their actual attitudes, perceptions, or behaviors. Response bias may be found in survey studies; that is, the respondents who completed the survey may be
different from the providers that did not complete the survey. Lastly, the sample of the oncology health care providers may not representative to all oncology health care providers nationwide.

This study addresses the following research questions:
(1) what is oncology health care providers’ level of cultural competence? (2) Does current career type of oncologic health care providers influence cultural competence? (3) Does attending prior diversity training of oncologic health care providers influence cultural competence? (4) Are educational variables and provider’s personal characteristics related to levels of cultural competence?

Sampling

The participants that were involved in this study were recruited from the Department of Oncology/Hematology at Kaiser Permanente in the city of Riverside, California. This facility is an outpatient chemotherapy treatment clinic for cancer patients. This availability-convenience sampling strategy had an inclusion criterion of the participants who are providing any type of health care service to an oncology patient and are currently employed
in field of oncologic health care. This sample was selected to examine culturally competent practice with oncologic patients at an outpatient chemotherapy clinic, so the proper interventions may be implemented. The sample size for this quantitative survey student was 36 respondents.

Data Collection and Instruments

Descriptive data was collected from the respondents about their levels of cultural competence. A pre-existing empirically developed measurement, the cultural competence assessment survey, was designed specifically to assess the levels of cultural competence among health care professionals (Doorenbos et al., 2005). A modified version of the cultural competence assessment will be utilized to assess cultural competence among oncologic health care providers in an outpatient chemotherapy treatment clinic setting. This instrument was used to measure in the areas of cultural awareness/sensitivity and cultural competence behaviors (dependent variables).

There was one-item that measured the level of overall cultural self-competence. There were four-items that measured the respondent’s cultural diversity encounters. There was seven-items that measured the respondent’s level
of cultural awareness/sensitivity. There were seven-items that measured the respondent’s cultural competent behaviors. The subscale of cultural awareness/sensitivity used a five-point Likert-like response set of “strongly agree”, “agree”, “neutral”, “disagree”, and “strongly disagree.” The cultural competent behaviors subscale used a five-point Likert-like response set of “always”, “very often”, “often”, “sometimes”, and “never.” Demographic items included questions about the respondent’s age, gender, race or ethnicity, level of education, prior cultural diversity training, and description of current career title (independent variables).

Schim, Doorenbos, Miller, and Benket (2003) had initially developed the cultural competence assessment for the purpose of applying the instrument across a range of educational levels and backgrounds with interdisciplinary and multilevel health care professionals. The authors reported that the cultural competence assessment had a strong internal consistency reliability of 0.92, and the Cronbach’s alphas for the cultural awareness/sensitivity and cultural competent behaviors subscales were reported at 0.75 and 0.93 respectively. The authors also reported that content and face validity were established (Schim et al.,
2003). The limitation that was addressed stated that the cultural competence assessment relies on self-reporting of all aspects of cultural competence rather than observed knowledge, attitudes, and behaviors (Doorenbos et al., 2005).

Procedures

Permission was obtained from the Department Administrator to conduct this study at the Kaiser Permanente Oncology/Hematology Clinic in Riverside, California. The researcher distributed the self-administered cultural competence assessment questionnaires to voluntary participants. Voluntary participants consisted of oncologic health care providers, such as registered nurses, licensed vocational nurses, medical assistants, pharmacists, social workers, and oncologists. Participants were solicited at the facility site and asked to complete the questionnaire at their next earliest convenience. At the oncology chemotherapy facility, there was a designated area that had a drop box that collected anonymous questionnaires from respondents. Completion of the questionnaires by the respondents was within 15 to 20
minutes. Data was collected from January 14, 2014 to March 14, 2014.

Participants were provided with the informed consent letter and confidentiality statement, along with the self-administered questionnaires. The respondents indicated agreement to the terms of the informed consent by marking an “X” in the allocated line on the form. In order to ensure confidentiality, names were not elicited from the participants on the questionnaire. Upon completion of the questionnaire, all respondents was provided with a debriefing statement informing them the purpose of the study and information concerning how to obtain results. A raffle of a twenty-five ($25) dollar gift card from Starbucks Coffee was offered to voluntary participants of this study.

Protection of Human Subjects

Participation of the research was in an anonymous-voluntary basis. The study protected the participants by obtaining informed consent from every respondent in the study. Participants were informed that every possible effort will be taken to protect their anonymity and confidentiality. The researcher also informed the
participant that since this study is voluntary, they have the right to stop completion of the survey at any time. Additionally, a debriefing statement was provided in the survey packet for the respondent with phone numbers to contact in the event of any concerns or questions that may arise as a result of the conducted research.

Data Analysis

Data from the questionnaire was coded on and analyzed on Statistical Package for Social Sciences (SPSS) upon return of the surveys.

This project used quantitative data analysis techniques, such as, descriptive and inferential statistics. According to Grinnel and Unrau (2011), descriptive statistics describe variables of interest and how those variables are distributed in a sample. Inferential statistical tests explain the findings of either associations or differences between variables in samples (Grinnel & Unrau, 2011).

Descriptive statistics, including frequency distributions and measures of central tendency, will be employed to analyze demographic information (independent variables) and the cultural competence levels: cultural
awareness/sensitivity and culturally competent behaviors (dependent variables). Inferential statistics, such as independent t-test and one-way analysis of variance (ANOVA) will also be employed. An independent sample t-test will be employed to compare the means of the dependent variables of cultural competence by the independent variables, such as gender and current career role. Finally, a one-way ANOVA will be employed in order to compare the means of the dependent variables by level of education, current career role, and prior cultural diversity training.

Summary

This chapter addresses the methods that were appropriately used for study design. Procedures for recruiting sample participants were discussed, followed by data collection and instrument. Examination of data procedures and the protection of the human participants were also discussed. This section concluded with the discussion of measures that was used to process and refine data analysis.
CHAPTER FOUR
RESULTS

Introduction

This study explored the level of oncology health care providers’ cultural competence (sensitivity/awareness and behaviors). This also included examining the oncology health care provider’s cultural experience in the workplace, self-assessment of cultural competence, educational factors and staff characteristics that may influence the level of cultural competence practices. This chapter presents the study findings which includes the demographic characteristics, self-assessment of cultural competence, previous diversity training, overall level of cultural competence, and analysis of research questions. This chapter will conclude with a summary of the findings.

Presentation of the Findings

Forty (40) questionnaires were given to the oncology health care providers in the Oncology Department in Kaiser Permanente Riverside. A total of 36 oncology health care providers completed the voluntary self-administered questionnaire on cultural competence. This study had a high
response rate of 90%. All 36 respondents completed all portions of the questionnaire, including the demographic information.

Table 1. Demographic Characteristics of Oncologic Health Care Providers

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>TOTAL N</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td>N = 36</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>(19.4%)</td>
</tr>
<tr>
<td>Female</td>
<td>29</td>
<td>(80.6%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<td>Mean = 44.1</td>
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<tr>
<td>27-35 years</td>
<td>9</td>
<td>(25.0%)</td>
</tr>
<tr>
<td>36-45 years</td>
<td>12</td>
<td>(33.3%)</td>
</tr>
<tr>
<td>46-55 years</td>
<td>10</td>
<td>(27.8%)</td>
</tr>
<tr>
<td>56-65 years</td>
<td>4</td>
<td>(11.1%)</td>
</tr>
<tr>
<td>66-70 years</td>
<td>1</td>
<td>(2.8%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>N = 36</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>11</td>
<td>(30.6%)</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>9</td>
<td>(25.0%)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>3</td>
<td>(8.3%)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>13</td>
<td>(36.1%)</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>(5.6%)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>N = 36</td>
<td></td>
</tr>
<tr>
<td>High School Graduate/G.E.D.</td>
<td>1</td>
<td>(2.8%)</td>
</tr>
<tr>
<td>Some College/Associate Degree</td>
<td>9</td>
<td>(25.0%)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>14</td>
<td>(38.9%)</td>
</tr>
<tr>
<td>Graduate/Professional Degree</td>
<td>12</td>
<td>(33.3%)</td>
</tr>
<tr>
<td><strong>Career Title</strong></td>
<td>N = 36</td>
<td></td>
</tr>
<tr>
<td>M.A.</td>
<td>1</td>
<td>(2.8%)</td>
</tr>
<tr>
<td>L.V.N.</td>
<td>2</td>
<td>(5.6%)</td>
</tr>
<tr>
<td>R.N.</td>
<td>15</td>
<td>(41.7%)</td>
</tr>
<tr>
<td>Clerical Worker</td>
<td>1</td>
<td>(2.8%)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>6</td>
<td>(16.7%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>5</td>
<td>(13.9%)</td>
</tr>
<tr>
<td>Physician/M.D.</td>
<td>3</td>
<td>(8.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>(8.3%)</td>
</tr>
</tbody>
</table>
Table 1 presented the demographic characteristics of all oncology health care provider respondents. Most respondents were female (80%) and the remaining respondents (20%) were male. A third of the respondents (33.3%) were in the 36 to 45 age range and 27.8% were in the 45 to 55 age range. Among the oncology health care provider respondents, the two largest racial/ethnic groups were Asian/Pacific Islander (36.1%) and Hispanic/Latino (30.6%). Most of the respondents have completed a Bachelor’s Degree (38.9%) as their highest educational achievement. Regarding types of career, 42% of the respondents were registered nurse, followed by pharmacists (16.7%) and social workers (13.9%).

Table 2. Oncologic Patients of Oncologic Health Care Providers

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>N (%)/Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Racial/Ethnic Groups Encountered in Past 12 months</strong></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>5 (13.9%)</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Yes</td>
<td>31</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>5 (13.9%)</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Yes</td>
<td>31</td>
</tr>
<tr>
<td>Black/African American</td>
<td>4 (11.1%)</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Yes</td>
<td>32</td>
</tr>
<tr>
<td>American Indian</td>
<td>31 (86.1%)</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>7 (19.4%)</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>Special Population Encountered in Past 12 Months</td>
<td>Yes</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Mentally Challenged</td>
<td>27</td>
</tr>
<tr>
<td>Physically Challenged</td>
<td>32</td>
</tr>
<tr>
<td>Homeless</td>
<td>33</td>
</tr>
<tr>
<td>Drug/Alcohol Abuse</td>
<td>26</td>
</tr>
<tr>
<td>Gay/Lesbian</td>
<td>25</td>
</tr>
<tr>
<td>Different Religious Background</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Racial/Ethical Population</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>32.2</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>29.5</td>
</tr>
<tr>
<td>Black/African American</td>
<td>15.0</td>
</tr>
<tr>
<td>American Indian</td>
<td>0.6</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>16.9</td>
</tr>
<tr>
<td>Arab American/Middle Eastern</td>
<td>3.0</td>
</tr>
<tr>
<td>Other</td>
<td>2.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Special Population</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentally Challenged</td>
<td>20.9</td>
</tr>
<tr>
<td>Physically Challenged</td>
<td>26.6</td>
</tr>
<tr>
<td>Homeless</td>
<td>1.0</td>
</tr>
<tr>
<td>Drug/Alcohol Abuse</td>
<td>3.3</td>
</tr>
<tr>
<td>Gay/Lesbian</td>
<td>3.2</td>
</tr>
<tr>
<td>Different Religious Background</td>
<td>33.0</td>
</tr>
<tr>
<td>Other</td>
<td>4.3</td>
</tr>
</tbody>
</table>
Table 2 describes the encountered oncology patients (racial/ethnic and special population) of the oncologic health care providers. Amongst all the racial/ethnic populations that the oncologic health care providers have encountered mostly were Black/African American at 90.0%, Hispanic/Latino at 86.1%, White/Caucasian at 86.1%, and Asian/Pacific Islander at 80.6%. For encounters with patients of a special population, respondents reported that patients who have physical challenges were the most encountered at 88.9% and second most encountered are patients who have different religious backgrounds (83.3%). Of the racial/ethnic populations, oncology health care providers’ reported to encounter a patient of Hispanic/Latino background 33% of the time. Of the special populations, the oncology health care providers reported to encounter persons with different religious backgrounds 33% of the time.
Table 3. Self-Assessment of Cultural Competency and Previous Cultural Competency Training

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>TOTAL N</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Assessed Cultural Competency</strong></td>
<td>N = 36</td>
<td></td>
</tr>
<tr>
<td>Very Competent</td>
<td>16 (44.4%)</td>
<td></td>
</tr>
<tr>
<td>Somewhat Competent</td>
<td>16 (44.4%)</td>
<td></td>
</tr>
<tr>
<td>Neither Competent nor Incompetent</td>
<td>2 (5.6%)</td>
<td></td>
</tr>
<tr>
<td>Somewhat Incompetent</td>
<td>1 (2.8%)</td>
<td></td>
</tr>
<tr>
<td>Very Incompetent</td>
<td>1 (2.8%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cultural Diversity Training</th>
<th>N = 36</th>
<th>YES = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate College Course for Credit</td>
<td>7 (19.4%)</td>
<td></td>
</tr>
<tr>
<td>Content Covered in a College Course</td>
<td>5 (13.5%)</td>
<td></td>
</tr>
<tr>
<td>Professional Conference or Seminar</td>
<td>11 (30.6%)</td>
<td></td>
</tr>
<tr>
<td>Employer-sponsored program</td>
<td>26 (72.2%)</td>
<td></td>
</tr>
<tr>
<td>On-line Education</td>
<td>6 (16.7%)</td>
<td></td>
</tr>
<tr>
<td>Continuing Education Offering</td>
<td>7 (19.4%)</td>
<td></td>
</tr>
<tr>
<td>Other Diversity Training Types</td>
<td>2 (5.6%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 describes frequency distribution of the self-assessed cultural competency item and previous cultural diversity training items of the respondents. Most respondents (88.8%) seemed to have a “very competent” and “somewhat competent” self-assessment on their cultural competency. Regarding previous cultural diversity training, almost all of the respondents (86%) reported that they had at least one type of previous diversity training. Of those respondents who have previous cultural diversity training, almost 73% reported attending an employer-sponsored program and around 30% of the respondents reported attending a
professional conference or seminar about cultural diversity.

Table 4. Cultural Competency: Cultural Awareness/Sensitivity

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>TOTAL N</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Race is the most important factor in determining a person’s culture.</strong></td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>3</td>
<td>(8.3%)</td>
</tr>
<tr>
<td>Agree</td>
<td>10</td>
<td>(27.8%)</td>
</tr>
<tr>
<td>Neutral</td>
<td>9</td>
<td>(25.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>10</td>
<td>(27.8%)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>4</td>
<td>(11.1%)</td>
</tr>
</tbody>
</table>

| **2. Many aspects of culture influence health and healthcare.** | 15     | (41.7%)    |
| Strongly Agree                                                        | 15     | (41.7%)    |
| Agree                                                                   | 4      | (11.1%)    |
| Neutral                                                                 | 2      | (5.6%)     |

| **3. Aspects of cultural diversity need to be assessed for each individual, group, and organization.** | 20     | (55.6%)    |
| Strongly Agree                                                         | 20     | (55.6%)    |
| Agree                                                                   | 10     | (27.8%)    |
| Neutral                                                                 | 4      | (11.1%)    |
| Disagree                                                                | 2      | (5.6%)     |

| **4. Spiritual and religious beliefs are important aspects of many cultural groups.** | 20     | (55.6%)    |
| Strongly Agree                                                         | 20     | (55.6%)    |
| Agree                                                                   | 12     | (33.3%)    |
| Neutral                                                                 | 3      | (8.3%)     |
| Disagree                                                                | 1      | (2.8%)     |

| **5. Language barriers are the only difficulties for recent immigrants to the U.S.** | 4     | (11.1%)    |
| Strongly Agree                                                         | 4      | (11.1%)    |
| Agree                                                                   | 7      | (19.4%)    |
| Neutral                                                                 | 6      | (16.7%)    |
| Disagree                                                                | 11     | (30.6%)    |
6. I believe that everyone should be treated with respect no matter what their cultural heritage.

| Strongly Agree | 29 (80.6%) |
| Agree          | 4 (11.1%)  |
| Neutral        | 1 (2.8%)   |
| Strongly Disagree | 2 (5.6%) |

7. I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.

| Strongly Agree | 21 (58.3%) |
| Agree          | 10 (27.8%) |
| Neutral        | 3 (8.3%)   |
| Disagree       | 1 (2.8%)   |
| Strongly Disagree | 1 (2.8%) |

Table 4 presents the frequency distribution of cultural awareness/sensitivity items. As mentioned earlier, the cultural competence assessment is comprised of two subscales, cultural awareness/sensitivity and cultural competent behaviors. These subscales were derived from Doorenbos, Schim, Benkert, and Borse (2005) which is a modified version of Schim, Doorenbos, Miller, and Benket’s (2003) cultural competence assessment.

There are seven items for cultural awareness/sensitivity subscale of cultural competence assessment. For item 1, “race is the most important factor in determining a person’s culture”, nearly 39% of providers responded with “disagree” or “strongly disagree” with the
statement. Over 36% of the respondents reported to “agree” or “strongly agree” with the statement. For item 2, “many aspects of culture influence health and healthcare”, 83.4% of the respondents reported to “agree” or “strongly agree” with the statement. Only 5.6% reported that they either “disagree” with the statement.

For item 3, “aspects of cultural diversity need to be assessed for each individual, group, and organization”, 83.4 of the respondents reported to “agree” or “strongly agree” with the statement. Only 5.6% of respondents reported to “disagree” with the statement. For item 4, “spiritual and religious beliefs are important aspects of many cultural groups”, a large majority (88.9%) of the respondents reported to “agree” or “strongly agree” and only 2.8% reported to “disagree” with the statement. For item 5, “language barriers are the only difficulties for recent immigrants to the U.S.”, most of the respondents (52.8%) reported to either “disagree” or “strongly disagree” with the statement. About one-third of the respondents (30.5%) reported to either “agree” or “strongly agree” with the statement.

For item 6, “I believe that everyone should be treated with respect no matter what their cultural heritage”, an
overwhelmingly high majority of the respondents (91.7%) reported to “agree” or “strongly agree” with the statement. Only 5.6% of the respondents reported to “strongly disagree” with the statement. For item 7, “I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations”, nearly 87% of the respondents reported to “agree” or “strongly agree” with this statement. Almost 6% of the respondents reported to “disagree” or “strongly disagree” with this statement.

Table 5. Cultural Competency: Cultural Competent Behaviors

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>TOTAL N</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I ask clients and families to tell me about their own experiences of health and illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>3</td>
<td>(8.3%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>16</td>
<td>(44.4%)</td>
</tr>
<tr>
<td>Often</td>
<td>6</td>
<td>(16.7%)</td>
</tr>
<tr>
<td>Very Often</td>
<td>8</td>
<td>(22.2%)</td>
</tr>
<tr>
<td>Always</td>
<td>3</td>
<td>(8.3%)</td>
</tr>
</tbody>
</table>

2. I ask clients and families to tell me about their own expectations for care.

| Never | 3 | (8.3%) |
| Sometimes | 13 | (26.1%) |
| Often | 7 | (19.4%) |
| Very Often | 9 | (25.0%) |
| Always | 4 | (11.1%) |
3. I use a variety of sources to learn about the cultural heritage of other people.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>4</td>
<td>11.1%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>14</td>
<td>38.9%</td>
</tr>
<tr>
<td>Often</td>
<td>7</td>
<td>19.4%</td>
</tr>
<tr>
<td>Very Often</td>
<td>8</td>
<td>22.2%</td>
</tr>
<tr>
<td>Always</td>
<td>3</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

4. I avoid using generalizations to stereotype groups of people.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes</td>
<td>4</td>
<td>11.1%</td>
</tr>
<tr>
<td>Often</td>
<td>11</td>
<td>30.6%</td>
</tr>
<tr>
<td>Very Often</td>
<td>7</td>
<td>19.4%</td>
</tr>
<tr>
<td>Always</td>
<td>14</td>
<td>38.9%</td>
</tr>
</tbody>
</table>

5. I remove obstacles for people of different cultures when I identify barriers to services.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5</td>
<td>13.9%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>6</td>
<td>16.7%</td>
</tr>
<tr>
<td>Often</td>
<td>6</td>
<td>16.7%</td>
</tr>
<tr>
<td>Very Often</td>
<td>10</td>
<td>27.8%</td>
</tr>
<tr>
<td>Always</td>
<td>9</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

6. I welcome feedback from clients about how I relate to people from different cultures.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
<td>2.8%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>8</td>
<td>22.2%</td>
</tr>
<tr>
<td>Often</td>
<td>8</td>
<td>22.2%</td>
</tr>
<tr>
<td>Very Often</td>
<td>8</td>
<td>22.2%</td>
</tr>
<tr>
<td>Always</td>
<td>11</td>
<td>30.6%</td>
</tr>
</tbody>
</table>

7. I find ways to adapt my services to individual and group cultural preferences.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes</td>
<td>8</td>
<td>22.2%</td>
</tr>
<tr>
<td>Often</td>
<td>9</td>
<td>25.0%</td>
</tr>
<tr>
<td>Very Often</td>
<td>8</td>
<td>22.2%</td>
</tr>
<tr>
<td>Always</td>
<td>11</td>
<td>30.6%</td>
</tr>
</tbody>
</table>

Table 5 presents the frequency distribution of cultural competent behaviors items. There are seven items for the cultural competent behaviors subscale for cultural
competence assessment. For item 1, “I ask clients and families to tell me about their own experiences of health and illness”, nearly 45% of the respondents reported they would “sometimes” do this type of behavior. Over 22% of the respondents reported they would do this behavior “very often”. For item 2, “I ask clients and families to tell me about their own expectations for care”, almost 27% of the respondents agreed that they would “sometimes” so this behavior and only one-fourth of the respondents (25.0%) agreed that they would “very often” report doing this behavior. For item 3, “I use a variety of sources to learn about the cultural heritage of other people”, more than one-third (38.9%) of the respondents reported that they would do this behavior “sometimes” and almost one-fourth of the respondents (22.2%) reported that they would do this behavior “very often”. For item 4, “I avoid using generalizations to stereotype groups of people”, almost 39% of the respondents reported that they would do this behavior “always” and over 30% of the respondents reported they would do this type of behavior “sometimes”.

For item 5, “I remove obstacles for people of different cultures when I identify barriers to services”, a slight majority of the respondents (52.8%) reported that
they would do this behavior “very often” and “always”. Nearly 34% of the respondents reported that they would do this behavior “often” and “sometimes”. For item 6, “I welcome feedback from clients about how I relate to people from different cultures”, almost one-third of respondents (30.6%) reported on “always” for doing this behavior. Two-thirds of the respondents (66.6%) reported doing this type of behavior “sometimes”, “often”, and “very often”. For item 7, “I find ways to adapt my services to individual and group cultural preferences”, one-third of the respondents (30.6%) reported that they “always” do this type of behavior. One-fourth of the respondents (25.0%) reported to do this type of behavior “often”.

Analysis of Data by Research Question

There were four research questions that were the bases of this research study of cultural competence among oncology health care providers. These included exploring the overall level of cultural competence amongst oncology health care providers and the exploration of possible variables (career type and educational background) that may influence the certain levels of cultural competence.
Research Question One

Research question 1 addressed “what is the overall cultural competence level of oncology health care providers?” This question was examined by Doorenbos, Schim, Benkert, and Borse (2005) and their cultural competence assessment. Univariate analysis was used, more specifically frequency distributions, to understand the subscales of the overall cultural competency of the oncology health care providers. Majority (86.1%) of overall respondents had previous diversity training. Respondents reported to self-assess their competency of persons who are culturally different than their own. The majority (88.8%) of the respondents reported to be “somewhat competent” or “very competent.” Only 11.2% of respondents reported to be “neither competent nor incompetent,” “somewhat incompetent,” or “incompetent.”

There was a total of 36 respondents that completed the cultural competence assessment. This assessment is comprised of two subscales: cultural awareness/sensitivity and cultural competent behaviors. For the cultural awareness/sensitivity subscale there are seven items. The possible scores can range from 7 to 35. The score for the cultural awareness/sensitivity subscale is negatively
correlated, that is, the lower the respondents scored the higher the level of cultural awareness/sensitivity. In this study, the mean overall score for the cultural awareness/sensitivity scale was 13.5 \( (SD = 4.8, \text{ range } = 7 \text{ to } 27) \). This mean score was lower to moderate for cultural awareness/sensitivity subscale.

The possible scores of cultural competent behaviors ranged from 0 to 28, with the score of 0 being the lowest score and 28 being the highest score. The higher numerical value of the score, the higher the level of cultural competent behaviors. The respondents of this study had a mean score for the cultural competent behaviors subscale of 15.8 \( (SD = 6.5, \text{ range } = 5 \text{ to } 28) \). For cultural competent behaviors subscale, the mean score stands more moderate. Overall, the cultural competence of oncology health care providers resulted in a moderate level.

**Research Question Two**

Research question 2 explored the question, “does the career type of oncology health care providers have an influence of cultural competence?” Bivariate analysis, more specifically a Fisher’s test, was conducted to understand if the type of job of oncology health care providers influences the level of cultural competence. A one-way
ANOVA was conducted. The career types that scored the higher level of cultural awareness/sensitivity were registered nurses (mean = 12.3) and social workers (mean = 12.4). Unfortunately, the one-way ANOVA resulted in no significant differences among career types in the subscale of cultural awareness/sensitivity.

Similarly, the career types that scored the highest level of cultural competent behaviors were registered nurses (mean = 18.5) and social workers (mean = 20.2). The respondents that were among the lowest scored in the subscale of cultural competent behaviors were pharmacists (mean = 10.0) and physicians (mean = 8.0). Moreover, there was a significant difference in the type of job of oncology health care providers and the score of cultural competent behaviors, (F(7, 28) = 4.616, P < .01).

Research Question Three

Research question 3 addressed the “influence of previous diversity training have on oncology health care providers’ cultural competence level?” A bivariate analysis was conducted, more specifically an independent t-test, to understand the influence of specific previous diversity cultural training on oncology health care providers’ cultural competence level.
Oncology health care providers who had previous employer-sponsored diversity training scored a higher level of cultural awareness/sensitivity (mean = 13.4) than those who did not have employer-sponsored diversity training (mean = 15.0). Also, the respondents who have prior diversity training through online education scored a higher level of cultural awareness/sensitivity (mean = 12.5) than those who did not have prior diversity training through online education. Oncology health care providers who had previous diversity training through continuing education offering scored higher levels of cultural awareness/sensitivity (mean = 11.2) than those who did not have previous diversity training through continuing education offering (mean = 14.3). Moreover, results showed there was a significant difference in the level of cultural awareness/sensitivity in oncology health care providers who had prior diversity training through continuing education offering than those who did not have prior diversity training through continuing education offering, (t(28) = 21.2, p < .05).

Oncology health care providers who had prior diversity training in a professional conference or seminar scored a higher level of cultural competent behaviors (mean = 16.7)
than those who did not have diversity training through a professional conference or seminar (mean = 14.9). Oncology health care providers who had prior employer-sponsored diversity training have a higher cultural competent behaviors score (mean 15.9) than providers who did not have prior employer-sponsored diversity training (mean = 13.8). More importantly, the oncology health care providers who had previous diversity content covered in a college course scored significantly higher levels of cultural competent behaviors (mean = 19.6) than providers who did not attended previous diversity content covered in a college course (mean = 14.8, t(28) = 23.1, p < .01).

Research Question Four

Research question 4 asked “are educational variables and other personal characteristics related to levels of cultural competence?” A bivariate analysis was conducted (ANOVA) to show if the educational variable and other personal characteristics influence the level of cultural competence. The oncology health care providers that scored higher levels of cultural awareness/sensitivity were providers with a Bachelor’s Degree (mean = 12.6) compared to those with an Associate’s Degree (mean = 15.1) or Graduate’s Degree (mean = 13.4). Similarly, the oncology
health care providers with Bachelor’s Degree scored the highest levels of cultural competent behaviors (mean = 18.5) than those with an Associate’s Degree (mean = 15.1) or Graduate’s Degree (mean = 13.4). However, in both subscales there were no significant difference that was found.

Regarding the personal characteristic of age, in both subscales of cultural awareness/sensitivity and cultural competent behaviors, the oncology health care providers who are within the age range of 46 to 55 scored the highest levels (mean = 12.4; mean = 17.9) than those outside that age range. No significant differences were found amongst age and overall cultural competent level, \( F(4, 31) = .294, \ p > .05; \ F(4, 31) = 1.060, \ p > .05 \). Gender was not associated with the providers’ overall cultural competence level, \( F(1, 34) = .312, \ p > .05; \ F(1, 34) = .064, \ p > .05 \). This may be due to the possible sample size and the overwhelming number of female respondents.

**Summary**

A total of 36 oncology health care providers completed the cultural competence assessment. The results of this study suggests that the type of oncology health care
provider career influences the level of cultural competent behaviors, but not the level of cultural awareness/sensitivity. Those providers who are highest in cultural competent behaviors are registered nurses and social workers. The findings suggests that previous diversity trainings, in college courses and continuing education have a meaningful impact on the level of cultural competent behaviors, however, not on the level of cultural awareness/sensitivity.
CHAPTER 5

DISCUSSION

Introduction

The purpose of the study is to explore the level of cultural competence among oncology health care providers. This chapter presents a discussion of the results, major findings, implications, additional limitations, recommendations of future social work practice, policy, and research. This chapter will close with a conclusion section.

Discussion

This study examined the cultural competence level of oncology health care providers. The study indicated that the overall levels of cultural competence were lower (cultural awareness/sensitivity) to moderate (cultural competent behaviors). These are not satisfactory levels of overall cultural competence for health care professionals (Doorenbos & Schim, 2004). These findings were not consistent to the findings of Doorenbos and Schim (2004), which found that overall the hospice providers were generally culturally competent. These findings suggest that
oncology health care providers may need to complete
cultural competence training to further assist patients
with the appropriate culturally diverse practice of care.

In examining the cultural competence levels between
the types of health care careers, the findings of the study
showed a significant difference. The findings also showed
that registered nurses and social workers had the highest
mean scores in both cultural awareness/sensitivity and
cultural competent behaviors. Moreover, there was a
significant difference between the types of provider
careers and the subscale of cultural competence behaviors.
Oncology health care providers who were registered nurses
and social workers tended to report more frequent
culturally competent behaviors. These results were not
consistent with the findings of Polacek and Martinez
(2009), whose findings showed that the physicians scored
the highest in area of cultural awareness. Their study did
not examine cultural competent behaviors, however, they
examined skills. Polacek and Martinez (2009) reported no
significant difference in the area of skills; however they
found that physicians tended to score at a higher level in
cultural competent skills. In this study, physicians scored
the lowest in both subscales of cultural
awareness/sensitivity and cultural competent behaviors. These findings may suggest that registered nurses and social workers may have higher score in overall cultural competence because they are very likely to be more exposed to more diverse populations on a daily basis. This also indicates that although they have years of medical training, physicians may lack cultural appropriate practice.

This study found that those who had a Bachelor’s Degree tended to score the highest in both levels of cultural awareness/sensitivity and cultural competent behaviors. This study’s findings were not consistent with the findings of the study by Schim, Doorenbos, and Borse (2005). In that study, the findings showed that participants with a higher level of education tended to have higher scores on the cultural competence assessment (Schim et al., 2005). In this study, the majority of the registered nurses have Bachelor’s Degree as their highest educational degree and they seemed to have a higher overall score in the cultural competence assessment.

This study also explored the influence of cultural diversity training on the overall levels of cultural competence. Although overall there was no significant
difference in the level of cultural competence of respondents who have diversity training and those who did not have diversity training, there were findings of significant difference in certain types of diversity training. The findings showed that there was a significant difference in the level of cultural awareness/sensitivity of oncology health care providers who had prior diversity training through continuing education offering and those who did not have prior diversity training through continuing education offering. Furthermore, the findings showed that there was a significant difference in the level of cultural competent behaviors of oncology health care providers who had previous diversity content covered in a college course and providers who did not attended previous diversity content covered in a college course. This study’s findings on cultural diversity training were not consistent with the findings of Doorenbos and Schim (2004) and Schim, Doorenbos, and Borse (2005). Those studies found a significant difference in the health care providers who reported prior diversity training and those who did not report prior training. This suggests that completing certain types of diversity training may not be sufficient enough to become culturally competent in the health care
practice. Consistent continuing diversity training for health care providers may substantiate higher level of cultural competency.

Limitations

There are several limitations of this study. The study’s small convenience sample size is a limitation. There were only 36 out of 40 voluntary participants that completed the questionnaire. Those who did not complete their questionnaires may have different levels of cultural competence from those who did complete their questionnaires. This is a threat to external validity in that the sample may not be generalized to the typical oncology health care providers that are in the US. Additionally, the sample had an overabundance of respondents whose job title was registered nurse. There is difficulty to accurately compare the levels of cultural competence among various health care provider career types. Additionally, there is a limitation in the method of self-reporting from the respondents. The method of self-reporting can lead to respondents answering dishonestly and to researcher bias. This is the tendency of participants...
trying to affect the research study with socially acceptable answers in the questionnaire.

Recommendations of Social Work Practice, Policy, and Research

As stated in the (National Association of Social Workers, 1999), social workers must have ethical commitment to their client to provide culturally competent services. Cultural competence is a process and is a daily application in the social work profession. Exploring the role of cultural competency in the care of oncology patients is essential in social work direct practice, policy, and future research.

This study found that not all oncology health care provider participants had completed some type of cultural diversity training. This indicates a need for oncology health care providers to have continuing education or have cultural diversity training. The result found that oncology social workers tended to score at a higher level in cultural competency. This is a promising result for the social work field because it suggests the emphasis of care and service applied on the patient’s culture and diversity.
There is a critical need of some type of cultural diversity training for oncology health care providers. From this study’s findings, the types of cultural diversity training that have some meaningful impact would be either continuing education or content covered in college courses.

A recommendation for oncology department administrators would include considering more frequent offerings of cultural diversity training and education to all health care providers, especially for physicians and pharmacists who tended to have lower levels of cultural competence. Amplifying the importance of cultural diversity training for all health care providers may possibly increasing the cultural competency. This study found that all professional schools need to include content on cultural competence in their curriculum to possibly provide a foundation of culturally competent health care service.

Further studies could look into what specific aspects of diversity training when teaching health care providers. It is important to longitudinally assess the sustainability of the diversity training to cultural competent practice of oncology health care providers with cancer patients. Future studies should also consider assessing how health care
providers’ cultural competency affects their cancer patients’ treatment outcomes.

**Conclusion**

The purpose of the study was to examine the cultural competence among oncology health care providers. This study assessed the levels of cultural awareness/sensitivity and cultural competence behaviors. Furthermore, the research assessed the factors that may have influence on the levels of overall cultural competence. This study explored how career title, previous diversity training, and educational factors influence the overall level of cultural competence. There showed a significant relationship between career titles and levels of cultural competence. Registered nurses and social workers seemed to have the highest level of cultural competence. The study suggests that there should be emphasis of cultural competence practice in the field of social work.
APPENDIX A

QUESTIONNAIRE
Cultural Competence Assessment Survey

This survey is designed to learn more about the cultural competence among oncology health care providers. There are no right or wrong answers, and your responses will remain anonymous. Please check or circle the answer that is right for you. After you complete the survey please return it back to the researcher.

The following questions are designed to find out your cultural diverse encounters. Please read each of the following items carefully, thinking about how it related to your life, and then indicate how true it is for you.

A1. In the past 12 months, which of the following racial / ethnic groups have you encountered among your clients and their families or within the healthcare environment or workplace? *Mark 'X' for all that apply.*

- _____ Hispanic / Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- _____ White / Caucasian / European American
- _____ Black / African American
- _____ American Indian / Alaska Native
- _____ Asian / Native Hawaiian / Pacific Islander (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- _____ Arab American / Middle eastern
- _____ Other (specify)__________________________________________

A2. In your current environment what percentage of the total population is made up of people from these racial/ethnic groups? *Write in percents to add to 100%*

- _____ Hispanic / Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- _____ White / Caucasian / European American
- _____ Black / African American
- _____ American Indian / Alaska Native
- _____ Asian / Native Hawaiian / Pacific Islander (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- _____ Arab American / Middle Eastern
- _____ All other groups combined
A3. In the past 12 months which of the following special population groups have you encountered among your clients and their families or within the healthcare environment or workplace?

*Mark 'X' for all that apply.*

- Mentally or emotionally challenged / disabled
- Physically challenged / disabled
- Homeless / housing insecure
- Drug / alcohol abusers
- Gay, lesbian, bisexual, or transgender
- Different religious / spiritual backgrounds
- Other (specify)

A4. In your current environment what percentage of the total population is made up of people from these special population groups?

*Write in percents; may not total 100%*

- Mentally or emotionally challenged / disabled
- Physically challenged / disabled
- Homeless / housing insecure
- Drug / alcohol abusers
- Gay, lesbian, bisexual, or transgender
- Different religious / spiritual backgrounds
- Other (specify)
Please read each of the following question carefully, thinking about how it related to your life, and then indicate by placing an ‘X’ in the box that best describes how you feel about the statement.

B1. Overall, how competent do you feel working with people who are from cultures different than your own?

Very competent          Somewhat competent          Neither competent nor incompetent          Somewhat incompetent          Very incompetent

The following questions are designed to find out your cultural sensitivity, awareness, and competent behaviors. Please read each of the following items carefully, thinking about how it related to your life, and then indicate how true it is for you. Please circle your answer.

C1. Race is the most important factor in determining a person’s culture.

Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

1  2  3  4  5

C2. Many aspects of culture influence health and healthcare.

1  2  3  4  5

C3. Aspects of cultural diversity need to be assessed for each individual, group, and organization.

1  2  3  4  5

C4. Spiritual and religious beliefs are important aspects of many cultural groups.

1  2  3  4  5

C5. Language barriers are the only difficulties for recent immigrants to the United States.

1  2  3  4  5

C6. I believe that everyone should be treated with respect no matter what their cultural heritage.

1  2  3  4  5

C7. I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.

1  2  3  4  5
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<tr>
<td>C8.</td>
<td>I ask clients and families to tell me about their own explanations of health and illness.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>C9.</td>
<td>I ask clients and families to tell me about their expectations for care.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>C10.</td>
<td>I use a variety of sources to learn about the cultural heritage of other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>C11.</td>
<td>I avoid using generalizations to stereotype groups of people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>C12.</td>
<td>I remove obstacles for people of different cultures when I identify barriers to services.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>C13.</td>
<td>I welcome feedback from clients about how I relate to people from different cultures.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>C14.</td>
<td>I find ways to adapt my services to individual and group cultural preferences.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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TELL US ABOUT YOURSELF

D1. What is your age? ________________________

D2. Using the categories below, what do you consider yourself? *(Choose one)*

___ Female
___ Male

D3. Using the categories below, what do you consider yourself? *(Choose one or more)*

___ Hispanic / Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
___ White / Caucasian / European American
___ Black / African American
___ American Indian / Alaska Native
___ Asian / Native Hawaiian / Pacific Islander (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
___ Arab American / Middle eastern
___ Other (specify)__________________________________

D4. What is your highest level of education completed? *(Choose one)*

___ Less than high school
___ High school graduate or G.E.D.
___ Some college / Associate degree
___ Bachelors degree
___ Graduate or professional degree

D5. Have you ever participated in cultural diversity training? *(Choose one)*

___ Yes
___ No
D6. If you have had prior diversity training, which option below best describes it? (Check all that apply)

_____ Separate college course for credit
_____ Content covered in a college course
_____ Professional conference or seminar
_____ Employer-sponsored program
_____ On-line (computer assisted) education
_____ Continuing education offering
_____ Other diversity training types

(Specify)______________________________

D7. Which of the following best describes your current role? (Choose one)

_____ M.A.
_____ L.V.N.
_____ R.N.
_____ Clerical Worker
_____ Pharmacist
_____ Social Worker
_____ Therapist (occupational or physical)
_____ Physician / M.D.

Other (Specify)______________________________

Thank you for taking this survey. Please return the survey back to the researcher. We appreciate your time and effort!

This instrument was derived from:

APPENDIX B

INFORMED CONSENT
INFORMED CONSENT

The study in which you are being asked to participate is designed to investigate cultural competence among oncology health care providers. This study is being conducted by Junelle F. Gemarino a MSW student under the supervision of Dr. Janet C. Chang, Professor of the School of Social Work, California State University, San Bernardino. This study has been approved by the Institutional Review Board Social Work Subcommittee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to investigate cultural competence among oncology health care providers.

DESCRIPTION: Participants will be asked a few questions about culture competence and some demographics.

PARTICIPATION: Your participation in the study is completely voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY OR ANONYMITY: Your responses will remain anonymous and data will be reported in group form only.

DURATION: It will take 15 to 20 minutes to complete the survey.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There will not be any direct benefits to the participants.

CONTACT: If you have any questions or concerns about this study, please feel free to contact Dr. Janet C. Chang at (909) 537-5184.

RESULTS: You may receive the results of this study upon the completion of the study after December 2014, at the following location: California State University, San Bernardino, John M. Pfau Library.

By placing a check mark on the line below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. This is to certify that I read the above and I am 18 years or older.

Place an X mark here

Date

909.537.5501
5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393
APPENDIX C

DEBRIEFING STATEMENT
Debriefing Statement

This study you have just completed was designed to investigate cultural competence among oncology health care providers. The survey will be analyzed and the results will provide an indication of the level of cultural competence among oncology health care providers.

This study will provide an opportunity to measure cultural competence among oncology health care providers. The results of the study will indicate cultural competence among oncology health care providers.

Thank you for your participation and for not discussing the contents of the research with other participants. If you have any questions about the study, please feel free to contact Junelle F. Gemarino at gemarinj@coyote.csusb.edu or Professor Dr. Janet C. Chang at jchang@csusb.edu. If you would like to obtain a copy of the group results of this study, they will be available in the John M. Pfau Library at California State University, San Bernardino after December of 2014.
APPENDIX D

LETTER OF APPROVAL
November 8, 2013

Human Subjects Committee
School of Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, CA 92407

Dear Committee Members:

This is to confirm that Junelle F. Geminio has permission to carry out her research project on Cultural Competence Among Oncology Health Care Providers to assess cultural competence of oncology providers in service to cancer patients. We are committed to helping her retrieve her required data at the Oncology / Hematology Department in Kaiser Permanente Medical Center, Riverside facility. She plans to gather data from oncology health care providers by administering and collecting surveys from January 7, 2014 to July 7, 2014.

Sincerely,

[Signature]

Fita Lopez, R.N.
Department Administrator
Oncology / Hematology Department
REFERENCES


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