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Examining Cultural Competence in Health Care: Implications for Social Workers

Elizabeth Horevitz, Jennifer Lawson, and Julian C.-C. Chow

This article examines and unpacks the "black box" of cultural competence in health interventions with racial and ethnic minority populations. The analysis builds on several recent reviews of evidence-based efforts to reduce health disparities, with a focus on how cultural competence is defined and operationalized. It finds that the use of multiple similar and indistinct terms related to cultural competence, as well as the lack of a mutually agreeable definition for cultural competence itself, has resulted in an imprecise concept that is often invoked but rarely defined and only marginally empirically validated as an effective health intervention. This article affirms the centrality of cultural competence as an essential values-based component of optimal social work practice, while also suggesting future directions for operationalizing, measuring, and testing cultural competence to build an evidence base on whether and how it works to reduce health disparities.

KEY WORDS: *cultural competence; health care; health disparities, social work practice; social work values*

NASW's (2008) *Code of Ethics* regards cultural competence as a fundamental ethical standard for social work practice in all settings. There are, however, uncertainties regarding its meaning and application in social work practice, resulting in a "black box" of cultural competence in health interventions with racial and ethnic minority populations. Given that health disparities among ethnic minority groups have been partly attributed to cultural differences between patients and providers, there is an ongoing concerted effort to develop and implement culturally competent health interventions at both provider and institutional levels. The current health literature indicates that there is ambiguity regarding what exactly is meant by cultural competence as a construct, how it is operationalized in health-related interventions, and whether it improves health outcomes. This article describes the emergence of cultural competence in the health and social work literatures and traces the development of various theoretical models to explain this construct and its practical functions. It establishes what is known about cultural competence as a practice paradigm and health intervention and identifies gaps in the current knowledge base. Finally, future directions for research and social work practice in health settings are discussed.

OVERVIEW OF CULTURAL COMPETENCE

It is well established that racial and ethnic minority groups shoulder a disproportionate burden of negative health outcomes, a phenomenon broadly referred to as health disparities (Smedley, Stith, & Nelson, 2003; Snowden, 2005; Williams, 2002; Williams & Jackson, 2005). A burgeoning research literature on health disparities has shown unequivocally that individuals from minority racial and ethnic groups are disproportionately likely to develop severe health problems (such as diabetes, asthma, cancer, and heart disease) and to experience lower quality care and poor outcomes in relation to health problems even after controlling for multiple other factors such as socioeconomic status, insurance status, and age (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Smedley et al., 2003). The recognition of this problem—that race and ethnicity are social determinants of health—has made reducing these disparities a major focus of health care policy, research, administration, and practice in the United States (Betancourt et al., 2003; Smedley et al., 2003).

The majority of those in the helping professions, including social work, are from white middle-class backgrounds (Center for Health Workforce Studies and NASW Center for Workforce Studies, 2006; U.S. Department of Health and Human

Services, 2006). Studies of medical providers in multiple health care settings have shown that their interactions with patients of a different race or ethnicity can result in different diagnosis and treatment recommendations than those given to patients of the same race as the provider (Cooper, Powe, & Fund, 2004; Cooper-Patrick et al., 1999; Snowden & Holschuh, 1992). In their landmark review of health disparities for the National Institutes of Health, Smedley et al., (2003) identified discrimination (at both individual and system levels) as a causal agent in the health disparities experienced by racial and ethnic minorities in the United States.

In response to the growing recognition of the role of prejudice and discrimination in producing health disparities, an emphasis on cultural competence has emerged in the health professions (Betancourt et al., 2003). This emphasis can be seen across many domains of health care provision, including social work. Schools of social work are increasingly stressing cultural competence and building it into educational curriculums to promote optimal services and positive outcomes with diverse clients in different settings, including health care (NASW, 2001). Furthermore, legislative proposals on the federal level calling for cultural competence in health care education and practice have been increasing in recent years as part of a larger effort reduce racial and ethnic health disparities (Betancourt, Green, Carrillo, & Park, 2005).

Implicitly or explicitly, the impetus behind such efforts is the question: Can cultural competence in health care reduce health disparities? This question is complicated by the fact that cultural competence is defined differently by different researchers, organizations, disciplines, and educators. Literature often neglects to define the term "cultural competence" or even to discuss how culture itself is defined. In their seminal review of cultural competence interventions for health disparities, Brach and Fraserirector (2000) found that the majority of organizations and researchers that did define *cultural competence* used some variation of a definition from the mental health literature: "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 182). This definition is also used by NASW (2001).

Adding to the difficulties in studying the meaning and applications of cultural competence, multiple other terms are used in the literature to denote similar or identical constructs, including cultural humility, cultural sensitivity, cultural attunement, cultural proficiency, cultural tailoring, cultural awareness, transcultural awareness, multicultural sensitivity, multicultural competence, and cultural interventions. It can be difficult to parse the distinctions in meanings (where they exist) among these terms. For example, some articles use terms like "cultural sensitivity" interchangeably with "cultural competence," while others treat these terms as distinct (though related), with cultural sensitivity denoted as an antecedent to achieving cultural competence (Shen, 2004; Wells, 2000). Ultimately, the meanings of cultural competence and related terms are determined and operationalized in the contexts in which they appear, according to the definitions preferred by the author or organization.

Despite the abundance of terms related to or synonymous with cultural competence, greater understanding is needed on how this broad notion is applied in practice settings as an intervention to help eliminate health disparities. In other words, what does the literature tell us about the ways in which cultural competence is conceptualized and how it can be used as a practical vehicle for improving patient outcomes? A review of the literature identifies two main trends in culturally oriented models of health intervention: (1) those targeted at the individual provider level and (2) those targeted at the organizational or structural level.

Although this review cannot account for all possible conceptions of cultural competence, the subsequent section synthesizes relevant health care literature across many disciplines to examine some of the prominent models of how cultural competence translates from a concept to an intervention. The literature presented in this review indicates that although the importance of cultural competence in health practice has already been widely recognized in the fields of medicine, public health, and nursing, there is a paucity of social work literature conceptualizing this topic. A search of the electronic database Social Work Abstracts using the subject terms "cultural competence" and "health" yielded only two articles (Schultz, 2004; Torres & Rollock, 2007) both of which are primarily about mental health. Although social work has

historically emphasized cultural competence in practice settings such as mental health and child welfare (see, for example, Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Brave Heart, 2001; Fong & Gibbs, 1995; Livingston et al., 1994; McPhatter, 1999; Nash, Wong, & Trlin, 2006), it lags behind other disciplines in the development of knowledge about cultural competence specific to health care research and practice. Accordingly, most of the literature reviewed here originated in allied disciplines, but its applicability to social work is discussed throughout.

MODELS OF CULTURAL COMPETENCE: FROM PROVIDERS TO INSTITUTIONS

Provider-Level Cultural Competence

In micro-level frameworks, which focus on patient–provider interactions, providers are expected to overcome barriers presented by mismatches between the provider's and the patient's cultures that may impede efficacy of treatment due to different health beliefs, behaviors, and expectations (Tervalon & Murray-Garcia, 1998). Betancourt et al. (2003) addressed these provider-level cultural incongruities, identifying multiple areas in which cultural differences between patients and medical providers might influence decision making and result in health disparities. These potentially variant cultural factors include "patient recognition of symptoms; thresholds for seeking care; the ability to communicate symptoms to a provider who understands their meaning; the ability to understand the prescribed management strategy; expectations of care . . .; and adherence to preventive measures and medications" (Betancourt et al., 2003, p. 294). Cultural competence has emerged as a strategy to deal with these individual differences and overcome their potential to create misunderstanding and affect the treatment and outcomes of diverse patients.

A major way that health providers may overcome cultural barriers is by learning about the cultures of their patients and becoming aware of their own stigmas and biases (Campinha-Bacote, 2002; Papadopoulos, Tilki, & Taylor, 1998; Purnell, 2002). Providers who learn about the history, values, and beliefs of the cultural and ethnic groups to which their patients and clients belong can use this knowledge to overcome potential misunderstandings that result in disparate treatment and outcomes. Kim-Godwin, Clarke, and Barton (2001)

asserted that this learning process is part of developing cultural skills and involves a "culturological assessment" to "systematically examine beliefs, values, and practices of individuals, groups, and communities and to determine health care needs within the cultural context" (p. 922). Another prevailing view is that cultural competence is attained in a series of stages or a continuum. Although studies on social work, nursing, and medical literature all vary in their definitions of cultural competence, most have described a gradual gaining of cultural knowledge and its subsequent incorporation into behavior and clinical actions (see, for example, Campinha-Bacote, 2002; Cross et al., 1989; Isaacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996).

Using an evolutionary concept analysis of views on cultural competence from multiple disciplines (nursing, medicine, psychology, education, and social work), Suh (2004) created a comprehensive model of individual cultural competence that includes a thorough definition as well as the inputs and outputs of competent practice. She defined cultural competence as "an ongoing process with a goal of achieving ability to work effectively with culturally diverse groups and communities with a detailed awareness, specific knowledge, refined skills, and personal and professional respect for cultural attributes, both differences and similarities" (p. 96). She identified three major attributes of cultural competence: ability (to resolve cultural differences), openness (to respect diverse cultural groups), and flexibility (to adapt to different situations involving other cultures). In line with the view of cultural competence as a process with multiple stages, Suh identified antecedents in specific domains that must precede the attainment of cultural competence at the individual level:

- *cognitive*: appreciation of cultural diversity, awareness of the need for competence, foundational knowledge of other cultures
- *affective*: cultural sensitivity and respect for other cultures, perception and recognition of cultural differences
- *behavioral*: development of skills such as cultural assessment and intercultural communication
- *environmental*: cross-cultural encounters that create "an environment that allows cultural competence to ensue" (Suh, 2004, p. 98)

In this model, there is not only a progression of stages through which an individual provider achieves cultural competence, but also a variety of domains in which these stages occur. However, a difficulty with the definitions and processes described in this model is the lack of specificity in how to operationalize many of the necessary skills for achieving competence. For example, what does it mean, exactly, to "embrace culturally relativistic perspective, intersubjectivity, and commitment to and appreciation of other cultures" (Suh, 2004, p. 98)? Similarly, how do people know when they have achieved sufficient cultural awareness and knowledge within the cognitive domain? Although this lack of clarity presents a limitation to the applicability of her model, Suh (2004) is not alone in offering a conceptual framework that is difficult to translate from theory to practice.

Wells (2000) synthesized prior models to present a two-phase (cognitive and affective) continuum with the ultimate desirable outcome being cultural proficiency (p. 192), which she considered a step beyond cultural competence. The cognitive phase moves from cultural incompetence (insufficient knowledge of the implications of culture on health behavior) to cultural knowledge (a working knowledge of various elements of culture and how they affect behavior) to cultural awareness (recognition of the impact of culture on health). The affective phase moves from cultural sensitivity (integrating knowledge of culture into practice) to cultural competence (routinely applying cultural knowledge in practice). Cultural proficiency, the ultimate goal, "includes mastery of the cognitive and affective phases of cultural development" (p. 192).

This model, too, might create uncertainties for a practitioner trying to apply it to the pursuit of cultural competence. As an illustration, the model remains unclear on exactly what cultural knowledge consists of or how one moves, for example, from cultural knowledge to cultural awareness. Furthermore, one might question what cultural competence, according to Wells' definition (routinely applying cultural knowledge in health care) actually looks like in practice, or how it substantially differs from the previous stage of cultural sensitivity (integrating knowledge of culture into practice).

In another theoretical model, Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999) emphasized practitioner knowledge and the need for cultural sensitivity to promote health interventions and improve outcomes. The authors described two levels of cultural knowledge necessary for cultural competence: symbolic knowledge and deep knowledge. Symbolic cultural knowledge refers to understanding surface-level cultural characteristics such as food preferences, music, language, and clothing, and incorporating this information into practice to improve intervention acceptance. Deep cultural knowledge involves understanding how historical, environmental, and psychological forces influence behavior, and then incorporating that understanding into health interventions to be relevant to a target population.

Although the literature generally acknowledges that it is impossible to learn and know every possible cultural group's history and beliefs, Resnicow et al. (1999) demonstrated the continuing emphasis in cultural competence models on teaching providers about the general cultural beliefs of specific ethnic minority groups. Although useful, this technique has been increasingly criticized as superficial and having the potential to create stereotypes. For example, medical anthropologists Kleinman and Benson (2006) warned of the danger of culture being "made synonymous with ethnicity, nationality, and language . . . cultural competency becomes a series of 'do's and don'ts' that define how to treat a patient of a given ethnic background" (p. 1673).

Thus, a growing body of literature has begun to emphasize cultural competence in health care as an iterative process rather than an end-point goal for health care providers (Suh, 2004). Furthermore, given that health disparities have been linked to broader macro-level issues such as barriers to health care access and institutional discrimination, a growing number of models of cultural competence have moved beyond the provider–patient relationship and called for cultural competence on an institutional or structural level (Betancourt, Green, & Carrillo, 2002; Manoleas, 1994; Tervalon & Murray-Garcia, 1998; Wells, 2000).

Agency-Level Cultural Competence

Several literature reviews have attempted to summarize recommendations for achieving cultural competence at the institutional level. For example, Brach and Fraserirector (2000) identified the following nine techniques for achieving agency-

level cultural competence: providing interpreter services; establishing recruitment and retention policies to increase ethnic minority representation; providing training in cultural competence and sensitivity; coordinating with traditional healers in the community; using community health workers; carrying out culturally competent health promotion that incorporates cultural notions of health and well-being; including family and community members in care and decision making; provider immersion into another culture; and administrative and organizational accommodations, such as providing a welcoming environment and ensuring linguistic appropriateness of materials and information.

These nine techniques recognize that culture is embedded in a variety of broader domains beyond the micro-level provider–patient relationship. By promoting the incorporation of community health workers and coordinating clinic services with traditional healers, for example, this model extends the reach of the clinic into the community, addressing what Betancourt et al. (2003) referred to as "the inherent challenges in attempting to disentangle 'social' factors (for example, socioeconomic status, supports/stressors, environmental hazards) from 'cultural' factors vis-à-vis their influence on the individual patient" (p. 294). In this sense, such a model proposes not simply cultural competence but sociocultural competence, which acknowledges the broader social contexts in which cultural identities and behaviors are embedded (Betancourt et al., 2003).

Like Brach and Fraserirector (2000), Tripp-Reimer, Choi, Kelley, and Enslein (2001) also promote sociocultural approaches in health interventions, which involve attending to broad social environmental factors that may impede effective treatment as well as addressing specific cultural differences. The authors described the following continuum of interventions:

- *culturally neutral*: standard practice typically developed by Anglos for Anglos
- *culturally sensitive*: addresses issues of accessibility of services by using bilingual and bicultural health information materials, and incorporates surface-level cultural knowledge, such as dietary preferences, into practice
- *culturally innovative*: uses cultural symbols and notions of health and well-being to convey

health promotion messages, working with established social institutions in the community
- *culturally transformative*: involves principles of social activism and change to unearth power relationships and "partner with communities to alter aspects of the basic social structure" (p. 18)

The notion that social activism can or should be part of cultural competence, as seen in this model, underscores the idea that health disparities are rooted in larger systems of inequality and discrimination and has been echoed by others (for example, Flaskerud [2007]). The majority of cultural competence models, however, stop short of calling for broad social change.

Betancourt et al. (2003) identified institutional-level cultural competence as one necessary component of a health care system that "acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaption of services to meet culturally unique needs" (p. 294). The authors presented a three-tiered intervention framework—clinical, organizational, and structural—through which cultural competence can be implemented to reduce racial and ethnic health disparities. They emphasized the necessity of culturally competent interventions on all three levels, as organizational changes cannot improve minority health outcomes without concomitant changes in clinical practice and in the health care delivery system. In other words, given that factors at all of these levels contribute to disparate health outcomes for racial and ethnic minorities, they must all be addressed to equalize health outcomes.

This three-pronged framework identifies the following sociocultural barriers to care—(1) structural barriers, such as lack of interpreter services, bureaucratic intake processes, and difficulties accessing specialty care for minorities; (2) organizational barriers, such as lack of minorities in institutional leadership and the health care workforce; and (3) clinical barriers, such as poor provider–patient communication, provider stereotyping and discrimination, and misunderstanding of cultural perspectives on health issues—and suggests interventions at each level:

1. *structural*—improving access to and processes within the health care delivery system,

including expanding interpreter services and culturally appropriate health education
2. *organizational*—increasing diversity in the health care workforce and leadership
3. *clinical*—working to "enhance provider knowledge of the relationship between sociocultural factors and health beliefs and behaviors and to equip providers with tools and skills to manage these factors appropriately" (Betancourt et al., 2003, p. 298)

Thus, unlike the model by Tripp-Reimer et al. (2001), this model calls for some structural changes related to health care access. But it stops short of promoting larger-scale advocacy for systemic change, at least under the auspices of cultural competence.

In a more recent model, Organista (2007) called for agencies and health care providers to increase service availability and access, assess problems in their social and cultural context, select culturally and socially acceptable interventions, and increase accountability to recipients of services and their communities. Although this model was created with Latino populations in mind, its attention to health care barriers is relevant to multiple ethnic groups who experience health disparities. The author argued that by addressing these four major domains, agencies and practitioners can more systematically and comprehensively provide services that are responsive to the social and cultural needs of patients struggling with psychosocial and health problems. This model, too, presented key components of cultural competence at the institutional level (rather than merely the individual provider level), including engagement with the broader community, increased access to care for socioeconomically disadvantaged groups, and selection of interventions that are culturally appropriate.

What these models have in common is their attention to the role of macro-level factors as barriers to care in addition to provider-level barriers. In these models, the individual provider is expected to be culturally competent, but it is understood that to truly be effective in reducing health care disparities among racial and ethnic minority groups, the agency itself needs to adopt culturally competent practices on multiple systemic and organizational levels. Thus, cultural competence is conceived theoretically as an umbrella term for a multitude of individual-level skills and attitudes

and organizational-level practices and protocols. However, although these models theorize the process of attaining cultural competence at various levels, empirical understanding remains limited in regard to whether the various elements of cultural competence work to reduce health or health care disparities (Beach et al., 2005; Brach & Fraserirector, 2000). As can be seen from the previous examples, the sheer number of models and frequent ambiguousness of terms make the implementation of certain aspects of these models both challenging and subjective.

METHODOLOGICAL AND CONCEPTUAL LIMITATIONS IN THE EVIDENCE BASE

One of the major issues with the literature on cultural competence is the lack of strong empirical evidence on the difference various aspects of cultural competence make to actual health outcomes (Brach & Fraserirector, 2000; Carpenter-Song, Schwallie, & Longhofer, 2007; Castro, Barrera, Jr., & Martinez, Jr., 2004). Although several systematic reviews have suggested that intervention strategies that fall under the umbrella of cultural competence may be correlated with better health outcomes on a variety of measures (Chin, Walters, Cook, & Huang, 2007; Fisher, Burnet, Huang, Chin, & Cagney, 2007; Masi, Blackman, & Peek, 2007), rigorous analysis requires a critical look at how these strategies are defined and operationalized in intervention studies aimed at reducing racial and ethnic health disparities. Most of the current literature is descriptive and does not provide sufficient evidence to support the claim that cultural competence reduces health disparities (Callister, 2005). Furthermore, studies that use experimental designs may test only one aspect of cultural competence (as conceived by the models described earlier), but are cited throughout the literature as evidence for the effectiveness of cultural competence as a whole. For example, one frequently cited study (Jacobson et al., 1999) used a randomized controlled design to show that health education materials targeted at an appropriate literacy level and using appropriate language improved patient help-seeking behavior (request for and receipt of pneumococcal vaccination) as compared with a control group. Such studies make an important contribution to techniques to improve patient understanding of health education materials, but it is unclear how a finding like this fits into the broader concept of cultural

competence, of which language concordance is only one of many components.

Tripp-Reimer et al.'s (2001) article on the continuum of cultural competence in health care interventions provides another example of the ambiguity in understanding of cultural competence as an effective intervention. After presenting their continuum (as discussed earlier, from culturally neutral to culturally transformative), the authors stated:

> It is important to note that none of the levels of cultural intervention is necessarily "right" or better than the others. Each has a place in health care delivery. Practitioners need to thoughtfully identify which level is appropriate in different clinical situations given characteristics of the client, setting, health issue, and personal capabilities. (Tripp-Reimer et al., 2001, p. 18)

It would seem that if culturally neutral and culturally transformative interventions are equally right, then there are many unanswered questions about the circumstances under which each would be appropriate. Furthermore, although it is important that researchers do not promote unsubstantiated claims about the efficacy of interventions, the previously mentioned statement is symptomatic of a larger issue in the field: We want cultural competence to work, but there remain mixed messages about when, how, and why it can and should be used.

In a salient commentary, Flaskerud (2007) argued that cultural competence alone cannot resolve the issue of health disparities given the social context in which disparities occur, including unequal distribution of wealth, resources, power, and knowledge, as well as discrimination:

> Unfortunately, the identification of poverty and discrimination as important contextual factors for understanding social vulnerability to disease does not serve as a guide for effective action to reduce health disparities any more than does requiring cultural competence in health practitioners and researchers. For while the question of what needs to be done can be answered simply—reduce or eliminate poverty and discrimination—the methods for

accomplishing this are not clear. (Flaskerud, 2007, p. 432)

The question emerging from such critiques is: what do we know, and how well do we know it? The answer seems to be that although cultural competence is an increasingly valued framework for optimal practice among social workers and other health professionals, the empirical evidence is equivocal at best on whether this practice standard actually translates to reductions in disparity of health outcomes. There have been few head-to-head comparison trials of culturally competent versus "standard" or "neutral" health interventions. The majority of studies on culturally competent interventions are descriptive, and very few have looked at actual patient outcomes (Callister, 2005). A review by (Fisher et al., 2007) identified 38 interventions that used some form of culturally oriented interventions to target racial and ethnic health disparities. Although none of the studies in the review specifically compared the efficacy of a culture-specific intervention to that of a non-culture-specific intervention, the studies all used some form of cultural adaptation and the majority showed positive effects on measurable health outcomes. The authors concluded that culture-specific health care interventions showed promise in regard to reducing racial and ethnic health disparities. However, as the authors acknowledged, it is not possible to assess the causal impact of culturally adapted interventions compared with "generic" interventions due to the lack of control groups against which to make direct comparisons.

In addition to these methodological weaknesses in the current evidence base, there are questions of whether rigorous empirical study on this topic could ever capture the potentially complex and nuanced effects of culturally tailored interventions in the long term. Smyth and Schorr (2009) recently argued that the growing emphasis on experimental methods is dangerous when assessing interventions to improve outcomes for vulnerable populations:

> We pay too high a price when we give credence only to evidence that provides absolute assurance of change in a particular domain, for that threatens to skew our understanding of what constitutes a good intervention that changes lives, not one piece of a life. (Smyth & Schorr, 2009, p. 2)

Attempting to quantify cultural competence may also lead to rigidity in implementation that may be counterproductive to the core goal of cultural competence: to effectively reach all members of the community.

IMPLICATIONS FOR SOCIAL WORK RESEARCH AND PRACTICE

The theoretical haziness and weak empirical evidence, along with the doubts about whether cultural competence is an appropriate topic for experimental study, may seem to present a challenge for social workers. However, these issues need not threaten the continued development, practice, and promotion of cultural competence as a primary ethical standard for social workers. The core values of social work are well served by a strong focus on cultural competence. The mission and purpose of the social work profession demand respect for cultural diversity and practices that support this ethical commitment.

But beyond the affirmation of cultural competence as an essential social work value and standard, there remain unanswered questions about its effectiveness as an intervention to reduce health disparities. Such questions are important to avoid unsubstantiated claims regarding the evidentiary status of these practices. Social work researchers and practitioners concerned with these questions of effectiveness can actively help bridge the gap between theory and practice. Given that social workers practice in a wide array of health care settings, one possible way for them to build the knowledge base on cultural competence in health settings is through *practice-based evidence,* or the process of documenting and measuring real-world practice (Swisher, 2010), which can bolster the literature with specific best practices relevant to social workers in health care settings. Exploratory and descriptive case studies from direct practice can lay the groundwork for more rigorous scientific evaluation of promising practices with racial and ethnic minority populations and help further operationalize the theoretical components of cultural competence.

Considering that cultural competence is currently best understood as a broad umbrella term for multiple practices and techniques at both micro and macro levels, the following areas are ripe for further exploration and research:

- *Training in cultural competence.* Although there has been some research on cultural competence training among medical providers (Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2010; Tervalon & Murray-Garcia, 1998), many questions remain to be answered, such as the following: How does training in techniques such as "cultural humility" and "culturologic assessment" influence social work practice in health settings? What kind of training is most useful for social workers in health care settings, and how should it be delivered?

- *Engagement.* Effectively reaching and engaging racial and ethnic minority populations in health care settings remains a challenge at both the practitioner and agency levels. Outcomes of particular importance are improving health care access and utilization by racial and ethnic minority populations. The literature has identified some potentially promising practices in need of further investigation, such as using lay community health workers (Spencer, Gunter, & Palmisano, 2010; Swider, 2002) and coordinating with traditional healers and community outreach programs (Horowitz et al., 2008; Uba, 1992; Vera & Speight, 2003). In addition, at the agency level, recruitment and retention of racial and ethnic minorities in the health care workforce is an agreed-on component of cultural competence (Betancourt et al., 2003; Brach & Fraserirector, 2000), yet the search for effective methods for achieving this goal would benefit from additional research.

- *Treatment.* The effects of culturally tailored treatments on health status and level of functioning remain wide open for social workers to explore. Given the broad range of settings in which medical social workers practice, there is great potential for them to develop task-oriented and setting-specific research questions. For example, in the wake of health care reform, social workers will increasingly be employed in primary care settings as part of the greater medical-home movement (Druss & Mauer, 2010). This raises vital questions about what culturally tailored interventions social workers can use in these settings to more effectively manage chronic and acute health and mental health conditions in increasingly multicultural patient populations.

CONCLUSION

Although there are many similarities across models of cultural competence, ambiguous terminology and definitions inhibit the easy translation of theory into health practice settings. On a conceptual level, cultural competence is best understood as an umbrella term that embodies multiple techniques ranging from language and literacy concordance and cultural assessment of patients at the provider level to community outreach and minority workforce recruitment at the organizational level.

Although much of the literature points to the potential of cultural competence to reduce health disparities, there is limited evidence specifying whether different elements of cultural competence work to achieve this goal. The use of multiple similar and indistinct terms related to cultural competence, as well as the lack of a mutually agreeable definition for cultural competence itself, has resulted in an imprecise concept that is often invoked but rarely defined and only marginally empirically validated.

Cultural competence is presently operationalized so broadly that almost any technique can be claimed to be culturally competent. What is the cutoff point between interventions that are culturally competent and those that narrowly address demographic differences such as language? Although most social work and health researchers would agree that health disparities must be addressed through a cultural lens, operationalizing this process remains a challenge.

Cultural competence holds a rightfully central place in the values and ethical standards of the social work profession. However, to examine the effectiveness of cultural competence as a health intervention, additional research is needed to operationalize theoretical constructs, to develop salient research questions, and to carry out rigorous testing. Social work practitioners in health settings are well positioned to contribute to this process. In addition to exploratory or descriptive case studies to lay the groundwork for more rigorous quantitative research, qualitative accounts of experiences, or process, can help move the field toward a more cohesive agreement on how to operationalize cultural competence and which techniques under this broad construct are most effective. Social work practitioners can provide practice-based evidence to advance the development of effective and culturally competent techniques. In addition to using cultural competence as a values-based paradigm for optimal social work practice, further research on cultural competence as an intervention can inform the shift out of the black box into micro and macro levels of health care intervention. **HSW**

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