Improving ethno-cultural competence of hospital staff by cultural competence training (CCT) – Experiences from the European Migrant Friendly Hospitals project

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Overall goal and strategy of the MFH project 2002-05

Moving migration and cultural diversity higher up on the agenda of European hospitals and health policy by conducting a project with 12 Pilot Hospitals in 12 countries

Info on participants, strategies, experiences and results, including the Amsterdam Declaration on hospitals in an ethno-culturally diverse Europe

http://www.mfh-eu.net
mfh – 12 European Pilot Hospitals: Good coverage of EU 15

Kaiser-Franz-Josef-Spital, Vienna, Austria
Immanuel-Krankenhaus GmbH, Rheumaklinik Berlin-Wannsee, Berlin, Germany
Kolding Hospital, Velje-Kolding, Denmark
Hospital "Spiliopoulos Agia Eleni", Athens, Greece
Hospital Punta de Europa, Algeciras-Cádiz, Spain
Turku University Hospital, Turku, Finland
Hôpital Avicenne, Paris, France
James Connolly Memorial Hospital, Dublin, Ireland
Presidio Ospedaliero della Provincia di Reggio Emilia, Reggio Emilia, Italy
Academic Medical Center, Amsterdam, The Netherlands
Uppsala University Hospital, Psychiatric Centre, Uppsala, Sweden
Bradford Hospitals NHS Trust, Bradford, U.K.
Cultural competence training as one of three project interventions

- Based on results of a systematic needs assessment: Decision to invest in improving staff’s competences
  - by an integrated training course
  - targeting departments confronted with cultural diversity – all staff
- Primary orientation: Supporting staff to successfully handle/cope with challenges around cultural diversity
- Systematic evaluation as result of the Pilot character of the project
Interventions

- Gain managerial support and staff acceptance
- Ensure necessary resources
- Recruit trainers
- Conduct a specific needs assessment
- Adapt a proposed common curriculum to local needs
  - Provide introduction on CC in 2 sessions (max. 6 h)
  - Choose content of practical relevance
  - Include experiential learning as follow ups
  - Target awareness, knowledge, skills
  - Target a staff composition that allows for open communication: Similar work situations and problems, open communication also on hot topics like racism
- Conduct TRAINING
- Conduct evaluation
Documents/ Instruments developed and available on the Web

- A “fact sheet” summarizing the case for CCT
- A “Pathway” describing implementation
- “Modules” that specified a training design and content for specific parts
- An evaluation design and instruments, including
  - a documentation sheet
  - and a before – after staff questionnaire (CCCTQ), measuring change, adapted from an US example (Robert Like, project in family medicine for Aetna Foundation)
  - Benchmarking procedures at European project meetings
Evaluation Results - Overview

Feasibility/ Acceptability
8 of 12 pilot hospitals attempted implementation – 7 were successful in the agreed timeframe, total 143 training participants

Quality
Many compromises had to be made due to a narrow timeframe (measured as conformity with suggestions of the “Pathway”)

Effectiveness
Results went in the expected direction, varying across different dimensions and between hospitals

Cost-Effectiveness
External costs were low, but developmental costs high (expensive: convincing staff, recruiting trainers, scheduling trainings)

Sustainability
Inclusion in standard continuous professional education was in process by spring 2005 in 5 out of 7 pilot hospitals
# Measuring effectiveness: Changes of average score CCCTQ

<table>
<thead>
<tr>
<th></th>
<th>before training</th>
<th>after training</th>
<th>increase</th>
<th>Significance</th>
<th>valid cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td>2.48</td>
<td>2.98</td>
<td>0.5</td>
<td>**</td>
<td>N= 81</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td>2.38</td>
<td>2.79</td>
<td>0.41</td>
<td>**</td>
<td>N=77</td>
</tr>
<tr>
<td><strong>Comfort level</strong></td>
<td>2.84</td>
<td>3.16</td>
<td>0.32</td>
<td>**</td>
<td>N= 79</td>
</tr>
<tr>
<td><strong>Awareness</strong></td>
<td>3.91</td>
<td>4.17</td>
<td>0.26</td>
<td>**</td>
<td>N= 78</td>
</tr>
<tr>
<td><strong>Self awareness</strong></td>
<td>3.46</td>
<td>3.39</td>
<td>-0.07</td>
<td></td>
<td>N= 78</td>
</tr>
</tbody>
</table>

The scale ranges from 1 to 5. 1 = not at all, 2 = a little, 3 = somewhat, 4 = quite a bit, 5 = very. Scores vary between 1 – 5 with 4 being the highest self-rating of competence.
# Variations of effects between hospitals

<table>
<thead>
<tr>
<th></th>
<th>Lowest increase</th>
<th>Highest increase</th>
<th>Difference in increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>0,05</td>
<td>1,12</td>
<td>1,07</td>
</tr>
<tr>
<td>Skills</td>
<td>0,06</td>
<td>0,92</td>
<td>0,86</td>
</tr>
<tr>
<td>Comfort level</td>
<td>0,05</td>
<td>0,8</td>
<td>0,75</td>
</tr>
<tr>
<td>Awareness</td>
<td>0</td>
<td>0,49</td>
<td>0,49</td>
</tr>
<tr>
<td>Self awareness</td>
<td>-0,3</td>
<td>0</td>
<td>-0,3</td>
</tr>
</tbody>
</table>
Conclusions: CCT makes sense – but needs careful implementation

(1) Support by management is crucial
(2) Time and energy is needed to convince staff of relevance
(3) Training oriented at solving the real problems of everyday practice is more likely to be accepted – and more effective
(4) A skills-oriented design including experiential learning is useful but difficult to integrate with long working hours and changing shifts – full attendance in a 10 hour training is very difficult to integrate in busy hospital schedules
(5) Recruiting competent trainers is crucial – but the profile required for an integrated, skills oriented training is difficult to match
(6) Thus, splitting CCT should be tested – into two main parts.
   - a short generic introduction of the issue
   - combined with inclusion of cultural diversity issues into normal quality improvement routines of departments
Further Information

Cultural Competence Training (Subproject C): on the project website and in print in the journal:

Diversity in Health and Social Care

http://www.radcliffe-oxford.com/journals/J18_Diversity_in_Health_and_Social_Care/issues/
Examples for Effectiveness Evaluation: Selected skills items of CCCTQ

<table>
<thead>
<tr>
<th>Skills: How skilled are you in dealing with social-cultural issues in the following areas of the patient care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greeting patients in a culturally sensitive manner</td>
</tr>
<tr>
<td>Eliciting the patient’s perspective about health and illness (e.g., its etiology, name, treatment, course, prognosis)</td>
</tr>
<tr>
<td>Eliciting information about use of folk remedies and/or other alternative healing modalities</td>
</tr>
<tr>
<td>Eliciting information about use of folk healers and/or other alternative practitioners</td>
</tr>
<tr>
<td>Performing a culturally sensitive physical examination</td>
</tr>
<tr>
<td>Prescribing/negotiating a culturally sensitive treatment plan</td>
</tr>
</tbody>
</table>

Categories: Not at all (1), A Little (2), Somewhat (3), Quite a Bit (4), Very (5), Does not apply (Missing)
European cross analysis: The six most important problem areas

- Language and Communication: 12
- Patient info + education (linguistically & culturally adequate): 12
- Cultural barriers/lack of cultural competencies: 10
- Family visits: 7
- Lack of culturally adequate food: 6
- Spirituality and social support: 5

Number of hospitals where problem was mentioned (NA results from 12 pilot hospitals)