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The Client-Oriented Model of Cultural Competence in Healthcare Organizations

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Abstract

The paper aims to propose a new model of cultural competence in health organizations based on the paradigm of client orientation. Starting from a literature review, this study takes inspiration from dimensions that characterize the cultural competence of health organizations, and re-articulates them in more detail by applying a client orientation view. The resulting framework is articulated into six dimensions (Formal references; Procedures and practices; Cultural competences of human resources; Cultural orientation towards client; Partnership with community; Self-assessment) that define the ability of a health organization to achieve its mission, acknowledging, understanding and valorizing cultural differences of internal clients (staff) and external clients (consumers). This study makes an effort to address the paucity of studies linking approaches to managing cultural diversity in health organizations with cultural competence within the framework of client orientation.

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Introduction

Globalization has deeply changed the profile of both the workforce and the users of organizations in the societies of the new millennium. One important question is how to deal with growing cultural diversity in such a way that it may produce positive results – in terms of productivity and service quality, well-being and satisfaction – for organizational systems and for people, both workers and users.

The Diversity Management (DM) approach aims to accomplish such a result by adopting a heterogeneous viewpoint in order to lever cultural differences and treat them as an added value rather than an obstacle. In fact, the premise for managing diversity is the recognition of differences as positive attributes of an organization, rather than as problems to be solved [1]. In this way, diversity may become a source of competitive advantage, increase the quality of organizational life and ultimately be advantageous for business [2]. The point is not, therefore, the acceptance of differences, but the creation of an inclusive environment and the commitment to valuing them. This can be made possible through a culture of inclusion that creates a work environment nurturing teamwork, participation and cohesiveness. However, many organizations do not see the advantages that cultural diversity could bring to them and how well-managed cultural diversity may achieve a competitive edge in the market.

The topics of cultural differences and disparities that may result from them have been already described in healthcare organizations, since the emerging challenges of providing health services in a growing multi-ethnic world [3,4]; within these organizations, the approach of intercultural DM and the cultural competence are considered a priority. In particular, cultural

competence is a powerful instrument for managing cultural diversity in multicultural settings, since it improves quality and eliminates racial/ethnic disparities in organizations. The goal of cultural competence is to create a healthcare system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency.

Although cultural competence may be considered an important need for every contemporary organization, since the growing pressures of globalization to develop international influence or operating on an international scale, it is indeed a core requirement for healthcare organizations, since the exigency they have to respond to the specific needs of *any* person seeking help, and the related concerns who come from working with culturally diverse patient groups, in order to alleviate, at least in part, health disparities related to racial and ethnic differences.

The aim of this work is to propose a client-oriented model of cultural competence, meaning the ability of a health organization to acknowledge, understand and value cultural differences of internal clients (staff) and external clients (consumers), as well as the ability to commit to achieving its mission, taking account of clients' cultural identity and the individual needs. In order to respond to this objective, we reviewed the literature on cultural competence to identify a set of elements that define a culturally competent organization within the framework of client orientation. EBSCO, MEDLINE, Scopus, and Web of Science databases were searched for relevant peer-reviewed articles regarding the organizational cultural competence and client orientation in healthcare.

Towards a definition of cultural competence for health organizations

Since the 1980s, several scholars have paid attention to the construct of cultural competence, focusing on students [5-7], research [8], policy organizations [9], counseling services [10-12] and, above all, the human service sector – social work and healthcare [3,4,13-24]. With specific reference to healthcare organizations, the concept of cultural competence was used not only referring to the individual's ability to provide care in a culturally appropriate way, but also in relation to systems and organizations.

Cultural competence has been variously defined in literature. For example, Green [20] first defined it as the ability to conduct professional work in a way that is consistent with the expectations, which members of a distinctive culture regard as appropriate among themselves. This definition emphasizes the worker's ability to adapt professional tasks and work styles to the cultural values and preferences of clients. According to Cross et al., cultural competence «is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situation» [25,p.1]. Sue defines cultural competence as «the ability to engage in actions or create conditions that maximize the optimal development of client and client systems» [11,p.817]. According the National Quality Forum, cultural competence is «the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based and equitable» [26,p.2]. Last but not least, Betancourt et al. [3] define cultural competence as the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.

Despite these differences, authors seem to agree that cultural competence is an active and

developmental process that is ongoing and never reaches an endpoint. Cultural competence develops over time through training, experience, guidance and self-evaluation [4,14,25]. In connection to such a general statement, Campinha-Bacote views cultural competence in the specific field of healthcare as «the ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)» [4,p.181]. Scholars tend to consider cultural competence as increasingly important for healthcare quality [13,14,15,22], and believe that there is a link between cultural competence and reducing or eliminating racial and ethnic disparities in healthcare [7,16,27].

Although the centrality of cultural competence in health practice appears to be a widely accepted concept [3,13,14], still exists a scarce research on the effects and the outcomes of developing culturally competent healthcare organizations [16,28]. Nevertheless, there is some evidence that the implementation of cultural competence models improves the ability of health systems and their workers to provide services to culturally diverse patient groups, reducing disparities in quality of health care [13,15,16].

Main models of cultural competence

Several models of cultural competence have been developed in the last two decades; in them, the dimensions of this construct were delineated with particular attention to individuals and organizations.

Cross et al. [25], focusing on systems of care, propose a continuum that ranges from *cultural destructiveness*, that is destructive attitudes, policies and practices toward diverse cultures and individuals within a culture to *cultural proficiency* or *advanced cultural*

competence, i.e. attitudes, policies and practices that hold culture in high esteem, with the intermediate stages of *cultural incapacity*, in which the organization not intentionally seeks to be culturally destructive but rather is not able to help minority clients, *cultural blindness*, that is believing that all people are the same and that approaches used by a dominant culture are universally applicable, *cultural pre-competence*, namely realizing weaknesses in serving minorities and attempting to improve service for a specific part of the population, and *cultural competence*, i.e. adapting a service model to needs of minorities, expanding cultural knowledge and resources, conducting cultural self-evaluation continuously. In order to assess at which of these stages a given organization is, one may evaluate the entity of five essential elements that contribute to a system's ability to become more culturally competent: 1) the propensity to *valuing diversity*, that is the awareness, acceptance and respect of differences in lifestyle, communication, behaviors, values, attitudes; 2) the *cultural self-assessment*, specifically the ability of the system to assess itself and have a sense of its own culture; 3) the *dynamics of difference*, or the ability of the organization to manage misinterpretation and misjudgment when a member of one culture interacts with other from a different one; 4) the *institutionalization of cultural knowledge*, namely how much organization provide cultural knowledge to their workers about family system, values, history and etiquette of specific populations; and, finally, 5) the *adaption to diversity*, i.e. the sensibility of the organization to adapt its approaches in order to create a better fit between the needs of minority groups and services available.

Rodgers' model, instead, focuses on the identification of attributes of cultural competence rather than the development of a definition of the concept. Rodgers [29] identifies seven attributes of cultural competence: *cultural awareness*, i.e. developing consciousness of culture and the ways in which culture shapes values and beliefs; *cultural knowledge*, that is a

continued acquisition of information about different cultures and an essential underpinning of cultural understanding; *cultural understanding*, specifically the ongoing development of insights related to the influence of culture on the beliefs, values, and behaviors of diverse groups of people by which one can begin to address problems such as marginalization and subjection that may be the result of beliefs and values of one culture differing from those of the dominant culture; *cultural sensitivity*, that develops as one comes to appreciate, respect, and value cultural diversity and, in so doing, one also comes to realize how one's own personal and professional cultural identity influences practice; *cultural interaction*, namely the personal contact, communication, and exchanges that occur between individuals of different cultures; *cultural skill*, or the ability to communicate effectively with those from other cultures, including the incorporation of the client's beliefs, values, and practices into the provision and planning of care and also varying procedures and techniques to accommodate cultural beliefs; *cultural proficiency*, that is the commitment to change through some activities as the sharing of information.

A different model is proposed by Purnell [23]. It is based on the assumption that cultural competence is not a linear process in which a healthcare provider - or any organization - progresses from *unconscious incompetence*, a condition in which it is unaware that is lacking knowledge about another culture, to *conscious incompetence*, to one in which is aware, and from this to a state in which it has a *conscious competence*, learning about the client's culture and providing culturally specific interventions, to the optimal condition in which it automatically provide congruent care to clients of diverse cultures, namely it holds an *unconscious competence*.

Finally, Campinha-Bacote's model views cultural competence as the ongoing process

whereby the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community) [4]. Campinha-Bacote's model is composed of five major constructs that have an interdependent relationship with each other: *cultural awareness*, that is the self-examination and exploration of one's cultural and professional background; *cultural knowledge*, i.e. the pursuit and achievement of a sound educational foundation about diverse cultural and ethnic groups; *cultural skill*, namely the ability to collect relevant cultural data regarding the client's presenting problem, to conduct cultural assessments and culturally based physical assessments; *cultural encounters*, or the process that encourages the cross-cultural interactions between healthcare provider and clients from culturally diverse background; and, finally, the *cultural desire*, that is the motivation of the healthcare provider to want to become culturally aware, knowledgeable and skillful, and familiar with cultural encounters.

Though all the models presented so far have had some success and have been implemented in a wide variety of programs in medical schools, the concept of culture competence must go beyond the traditional notion of "competency", involving the fostering of a critical consciousness of the self, others, and the world and a commitment to addressing issues of societal relevance in healthcare [30]; also, they seem to consider cultural competence only as a means to provide a culturally specific service for users of different ethnicities.

The model here proposed, which we call the *Client-Oriented Model of Cultural Competence*, is instead designed mainly as a tool for management and development of human resources from different cultural backgrounds. In our proposal, a culturally competent organization aims to promote positive intercultural encounters firstly among colleagues, and secondly between providers and consumers. The organization must be culturally competent with

regard to internal customers to dispense a culturally competent service to external customers.

The Client-Oriented Model of Cultural Competence

The Client-Oriented Model of Cultural Competence can be considered as a model that, inspired by the DM approach, aims to link the task of managing cultural diversity in health organizations with cultural competence, within the framework of client orientation. In this model, the cultural competence is defined as the ability of a healthcare organization to achieve its mission (service delivery), acknowledging, understanding and valorizing cultural differences of internal clients (staff) and external clients (consumers).

Within the proposed model, we posit that the client orientation view may be considered a specific key element for healthcare organizations. In fact, the focus on provider-client relationship may give added value to healthcare services: for example, when healthcare providers either do not speak the client's language or are insensitive to cultural differences, the quality of health care can be compromised [13]. Under this point of view, a client-oriented healthcare organization is a system that responds effectively to language, and in a more general sense, to psycho-social needs of their clients. Also, the respect, the sensitivity, and the understanding for clients' culture and values appear to be related to the ability of healthcare providers to offer provisions of health services [3,4,13].

It is articulated into the following six dimensions:

1. Formal references related to cultural competence;
2. Procedures and practices;
3. Cultural competences of human resources;

4. Cultural orientation towards clients;
5. Partnership with community;
6. Self-assessment.

These dimension are described below in detail.

Formal references

The first dimension of the Client-Oriented Model of Cultural Competence regards written formal organizational statements about mission, values and principles, goals and policies, beneficiaries, vision. In a culturally competent organization, formal references explicitly stress the importance of cultural competence, consider the cultural diversity of staff members as a resource to be valuable and include members of different cultures as beneficiaries of the service. A culturally competent governance establishes policies and goals that help ensuring the delivery of the service in a culturally responsible way, by involving various groups in the decision making process [27]. The organizational statements must be communicated to staff and consumers, and the language in the formal references must acknowledge the cultural diversity of personnel and population served. In other terms, an organization is culturally competent when, even before delivering its services to implement the provision of services, defines its own primary task in a culturally sensitive way, taking care to distribute its own purposes, principles and values within the system and in the whole territory and encouraging the sharing of the same goals and principles among staff and users.

Procedures and practices

The second dimension regards the practices of management and development of human

resources. In relation to *service delivery procedures*, in agreement with Hernandez et al. [27], we believe that cultural competence in service ensures ad hoc services that reflect the needs of consumers. A healthcare organization should have a database containing information about each user's clinical history, culture of origin and reported impact ensuing the first encounter with the organization, to ensure a culturally competent service. This database, continuously updated, will be a guide for health providers, who will be able to provide the most appropriate service, in timely fashion and in the most appropriate way, to the specific patient. In relation to *management and development of human resources practices*, efforts should be made to recruit, select and hire multicultural administrative staff and medical personnel, who should be representative of the cultures existing in the community and able to speak the languages of the populations served [31,32]. Racial/ethnic diversity in the healthcare leadership and workforce has been clearly connected with the delivery of quality care to diverse patient populations [3].

So conceived, procedures and practices serve the more general objective to render a healthcare organization a culturally competent system; this, in turn, should allow to create a multicultural environment, which is a setting ready to receive people, both consumers and staff, of different cultures. In other words, a culturally competent organization, that has designed and created through its procedures and practices a physical and symbolic multicultural environment, ensures users' open access to services through the elimination of socio-cultural barriers [see 3,27]. Firstly, the absence of language barriers, i.e. multilingual brochures, documents/information materials allows effective communication between providers and consumers. The organization will monitor consumers' needs on site through such devices as anonymous questionnaires on the services offered.

As a customer-oriented system, the organization will offer the opportunity to provide

feedback also to the staff, who will be able thus to report problematic issues encountered in the workplace and provide suggestions to improve the service. Thus, the organization creates, maintains, and improves a work environment that is conducive to the well-being and development of all employees [17,33]. Such devices will increase the sense of belonging in the workplace (affective commitment) and employees will identify with the organization and its values. The physical-spatial structure with its premises and furnishings is nothing more than the expression of the organization's system of values based on acceptance, respect and appreciation of cultural differences. The culture of an organization, in fact, is primarily inferred from the observation of its visible and tangible aspects, along with the public actions of its members.

Cultural competences of human resources

The third dimension focuses on attitudes and skills of personnel required to provide culturally acceptable care, developed through training, which are: awareness of own beliefs and bias; knowledge, acknowledgment of, and respect for, beliefs and values of other cultures; relational skills in intercultural encounters with co-workers and consumers; appropriate language and effective communication; multicultural team-working skills. A large part of the literature suggests some of these beliefs/attitudes and skills are components of cultural competence [11,12,18,21,24,25]. In particular, Sue et al. [12] list some of the culturally competent counselor's attitudes and skills, namely: valuing and respecting differences in beliefs, values, language and helping practices; awareness and knowledge of own and clients' cultural heritage and experiences, attitudes, values, biases and stereotypes; ability to engage in a variety of verbal and nonverbal helping responses.

In our opinion, it is of primary importance that employees of multicultural organizations

be aware of the cultural basis of their behaviors, in such a way that they may realize that their beliefs do bear consequences on their actions in the workplace, possibly leading them to commit errors of assessment. It is also important that they know, accept and respect the different cultures of co-workers and users. In fact, if staff members are not willing to accept co-workers culturally different from themselves, they will always have difficulties welcoming external customers, which are carriers of culturally specific needs, and this attitude of closure shall affect the delivery of an efficient service. Relational, communication and team-working skills are necessary to work in a multicultural context. In general, with the acquisition of relational skills, employees become capable of managing intercultural encounters with colleagues and users, listening to others different from themselves, understanding their needs, and managing their own behaviors on the basis of their cultural characteristics.

Culturally competent organizations aim to reduce the difficulty of interaction (i.e., misunderstanding, conflicts, differences of views) between individuals of different cultures. To achieve this, it is also necessary to obtain specific multicultural team-working skills, which allow members to cooperate, share information, share their views, communicate effectively, and reach an agreement on the various clinical issues. Communication skills seem to be essential to interact and work in multi-ethnic groups. In order for the team's goal to be achieved and the environment to be positive, the communication must be clear and transparent, fluid and open, welcoming of others without judging, censorship or misunderstandings.

Upon meeting a culturally different customer, it is important the staff adapt their communication style and pay attention also to non-verbal communication. As claimed by Campinha-Bacote⁴, non-verbal communication techniques must take into consideration the client's use of eye contact, facial expressions, body language, touch, and space. Non-verbal

language and para-verbal language are the first channels of interaction and affect the transmission of the message more greatly than the spoken word. Communication with the user is effective if there is correspondence between the verbal and the non-verbal channels. Therefore, our model puts special emphasis on communication skills and improves relationships among colleagues and between providers and users.

The organizations need to render all employees more sensitive to cultural issues through diversity education and cultural competence training, teaching them culturally adapted models of care or types of interventions [31] and developing their attitudes and skills necessary to deliver service in a culturally responsible manner. Staff members will be involved in group discussions, i.e. case method and self-case method, and exercises, such as simulations, role playing which refer to their multicultural working environments, as well as outdoor training sessions centered on the relational and communication skills and multicultural team-working skills development.

The importance of diversity and cultural competence training and education is highlighted by a large part of literature [3,5,7,11,15,17,18,25,30,32,34-36], because cultural competence is mediated through the behavior of all human resources that act on both upper and lower levels of an organization. In this way, cultural competence does not stay a mere abstract concept, but rather it becomes a reflection of the skills, abilities and actions of every resource.

In general, the organization must focus on the development of such interpersonal skills in order to be customer-oriented from a cultural standpoint. If the organization grants its employees a chance to acquire and exercise these competences in their workplace relationships, they will also become able to deal with users belonging to any ethnic group in a culturally sensitive and responsible way.

Cultural orientation towards clients

The fourth dimension is the one that best qualifies the Client-oriented Model of Cultural Competence. It is the analysis of user and staff needs and it regards also the knowledge of their cultural characteristics. According to our definition, culturally competent organizations are culturally client-oriented, insofar as they proactively look to meet the cultural needs of both internal and external users. Already Hernandez et al. [27] and Siegel et al. [32] have stressed the importance of knowing the needs and cultural characteristics of the local population that constitutes most of the organization's user pool.

In our model, we take into consideration external customers, aware that cultural competence is an integral component of patient-centered care, but we plan to extend the analysis of needs and the knowledge of the cultural characteristics also to internal customers, because we consider an organization's care for its staff an essential element within the construct of cultural competence. We also believe that the cultural characteristics of staff affect not only the interaction with multicultural clients – and, therefore, the quality of service, but also the interpersonal relationships among colleagues. The quality of the latter must be guaranteed by the organization, through the promotion of effective communication styles and a positive emotional environment. These aspects of working life promote employee satisfaction, which will impact customer satisfaction in the assessment of Total Quality Management. According to this approach, in fact, the treatment of internal customer is transferred to the external customer. In other words, only if the organization is culturally competent with regard to staff, will it also be towards users. The ultimate goal is to provide quality service to multicultural users, but in order for an organization to be defined culturally competent, that organization must ensure a positive work environment for its own multicultural staff.

Partnership with community

Culturally competent healthcare organizations collaborate with community partners, such as other public, private or no-profit organizations that help minority groups. From such collaboration useful feedback may emerge regarding the analysis of the needs and cultural characteristics of ethnic groups served, upon which the organization sets its own targets for intervention. The community partners are therefore considered bridges, which bring together the providers and the consumers even before the latter start using the former's services [13,19].

Preliminary meetings, during social events organized periodically (i.e., friendly soccer matches in which healthcare professionals and users of different ethnicity play on the same team), permit the establishment of a relationship of trust, which will make the members of minority groups likely to turn to the organization for need of care. In other words, through this continuous dialogue with the territory, the organization makes culturally competent marketing, fostering relationships with potential multicultural users and making the service known to them, in a mutually advantageous process. With respect to minority communities' users, such a process increases their ability to manage their own health needs more autonomously and use services more responsibly and with the awareness that, once within the organization, they will find a welcoming environment.

Broadly speaking, healthcare organizations should develop collaborative partnerships with communities and use a variety of mechanisms, both formal and informal, to facilitate community and patient or consumer involvement in designing and implementing culturally and linguistically appropriate services related activities [13].

Self-assessment

Cross et al. [25] argue that the organization's self-assessment is essential to the development of its cultural competence. On the basis of literature [6,9,25], we highlight the importance of self-assessment on the part of a healthcare organization (qualitative and quantitative instruments), with particular attention to service quality, consumer satisfaction and personnel well-being. These three aspects are closely related and the evaluation of each of them is intertwined with the evaluation of the other two. The self-assessment is useful for the organization to continuously adapt its strategies. It is constituted as a continuous monitoring action, oriented to reviewing service delivery procedures, management practices and human resources development, with the ultimate goal of developing the most appropriate strategies for a culturally competent system. It is also useful to assess the quality of the service provided, in terms of process and product quality, from an intercultural standpoint.

It is useful to evaluate users' satisfaction, through the collection of their perceptions and opinions, by means of an on-site desk collecting questions and complaints as well as questionnaires submitted by users during their stay, with a constant focus on addressing the needs of different cultural groups. The on-site desk also allows internal clients to evaluate their own organization, expressing their opinions and suggestions to improve service. In this regard, meetings will be called periodically in order to analyze the data collected from various multicultural sources, discuss and give guidelines to staff on how to provide those services in a culturally competent manner.

Even the community partners play an important role in the evaluation process and in the examination of the results of service delivery procedures. By acting as representatives of particular ethnic groups present in the territory in which the services are provided, community

partners report those groups' needs to the organization. For example, an association representing the territory's Tamil community could bring up a specific need for this clinic ethnic group, the organization would take note and, on this basis, become able to develop culturally competent practices. In this self-assessment process, it is important for the organization to evaluate the welfare of its own multicultural staff. Even in this case, it is desirable to develop qualitative/quantitative questionnaires and focus groups.

Finally, the product evaluation aims to assess whether the organization's clinical and economic results have been achieved. There is no doubt that the self-assessment process will have positive repercussions on all ethnically diverse systems: leadership, on staff and users. Thanks to this self-assessment, it will be possible to deliver a high quality service in a culturally competent manner, managing to keep costs reduced and enhance the contribution of each human resource involved.

INSERT FIGURE 1

Conclusion

The six dimensions of the Client-Oriented Model of Cultural Competence interact with each other, according to a principle of circularity (see Figure 1). Even though, thanks to such circularity, each dimension naturally ensues the previous one, nevertheless the sequence cannot be considered too strictly in the study of an organization that is meant to assess whether it is culturally appropriate.

The theoretical model described here places previous conceptualizations of cultural competence under the paradigm of client orientation. By doing so, the success of efforts to

develop a culturally competent healthcare organization may be meaningfully influenced by the ability of the organization and their practitioners to recognize, value, and respond to the needs of the specific clients being served, not only those who belong to racial and ethnic minority groups; in this sense, the model considers a set of dimensions that have a pervasive influence in determining clients' health care experience. From this point of view, although the Client-Oriented Model of Cultural Competence identifies measurable dimensions associated with culturally competent organization, further research is needed to determine the best approaches and methods to measuring these factors. For example, the model may constitute the basis to develop a specific checklist to assist organizations to develop policies and structures that support a cultural competence specifically framed within the client orientation. Due to the multifaceted nature of the model, various indicators across multiple domains are required in order to obtain valuable and accurate information, but their identification goes beyond the purpose of this work.

An obvious broad implication of the adoption of the model here represented is, of course, that increased cultural competence can reduce disparities in provision of health care services. Conversely, at a more focused level, is important to distinguish between the cultural competence of individual practitioners of healthcare and cultural competence at the organizational level. At the individual level, some components of client-oriented cultural competence may be identified, for example, in the sensitivity and understanding of one's own cultural identity, in having knowledge of other cultures' beliefs, values and practices, and having the skills to interact effectively with clients' diverse (sub)cultures. At the organizational level, client-oriented cultural competence refers to a set of congruent policies, and structures that come together in a system: for example, creating structures for clients' commitment, in order to involve them in the design and implementation of services they receive, or developing partnerships that acknowledge

strengths and build upon a networks of support within diverse communities, taking into careful consideration the values and principles that underpin community engagement.

We believe that an organization is provided with cultural competence from the very moment in which it is created, insofar as its creation revolves around specific cultural values. These values will be acted upon through the organization's own practices and procedures, the development of specific skills within its staff and the consequent creation of a multicultural environment. In this model, the organization is also open to dialoguing with its territory and is willing to constantly self-evaluate its own actions.

All dimensions must be addressed in the cultural competence development process. To assess whether an organization is culturally competent, we posit that it is not necessary, however, to follow the order of dimensions suggested here. Therefore, in our circular model, it is possible to start from any dimension to proceed to the evaluation of any other one. For instance, if an organization is deemed culturally competent for the dimensions "Procedures and Practices" and "Partnerships with community", but it is not competent in regard to any other dimension, it is still possible to use those two successful dimensions to devise strategies to achieve competence in the others. When the tools are given to develop competence in all dimensions, the organization will have an orderly system and may operate independently in order to remain culturally competent.

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Figures

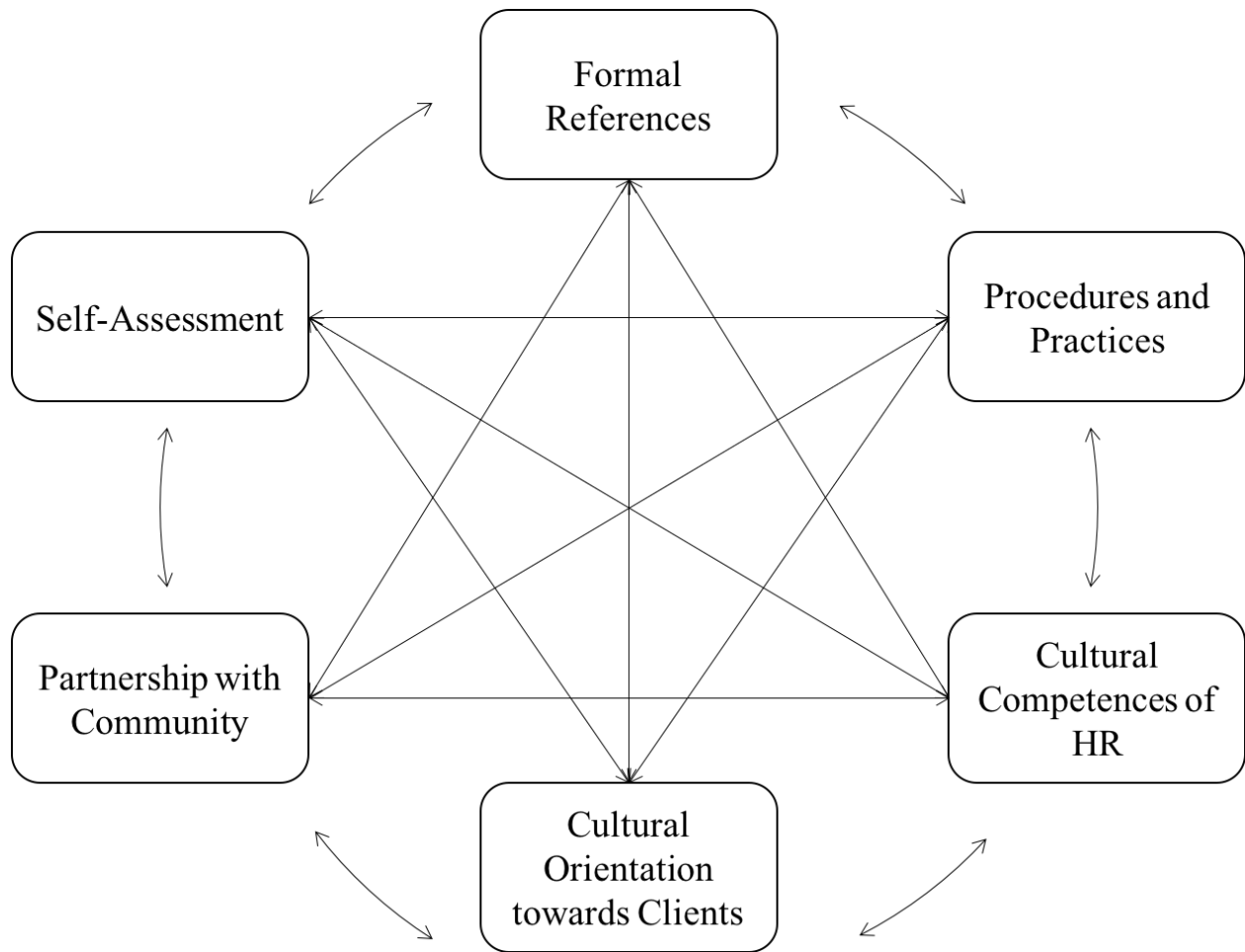


Figure 1. The Client-Oriented Model of Cultural Competence Diagram.